<table>
<tr><td colspan="2">
Akron Children's Hospital</td><td colspan="3">POLICY TITLE

Medication Administration</td></tr>
<tr><td>POLICY #</td><td>VERSION</td><td>CATEGORY</td><td colspan="2">SUB-CATEGORY</td></tr>
<tr><td>11297</td><td>1</td><td>☐Organizational</td><td>Choose a Policy Type.</td><td>Medical Staff Only -Choose a Policy Type</td></tr>
<tr><td colspan="2" rowspan="2">KEY WORDS
Click here to enter text.</td><td>☐Divisional</td><td>Choose a Division</td><td>Choose a Policy Type</td></tr>
<tr><td>☒Departmental</td><td>School Health Services</td><td>Clinical</td></tr>
<tr><td colspan="3">ORIGINAL DATE: 6/1/2014
CURRENT EFFECTIVE DATE: 5/25/2016
PREVIOUS REVISION/REVIEW DATES: 6/14 7/15 6/16</td><td colspan="2">THIS POLICY REPLACES:
Click here to enter text.</td></tr>
<tr><td colspan="5">APPLICABILITY:
☒Akron Children's Hospital & Affiliates

☐Children's Home Care</td></tr>
</table>

Contact Person/Position: Michele Wilmoth/Director		Pages: 2
SPECIAL REVIEW		**ADMINISTRATIVE REVIEW**
☐Environmental of Care/Safety	☐Medical Staff	☐Administrative Staff
☐Health Information Management	☐Nursing Guidelines	☐Board of Directors
☐Human Resources	☐Patient Services	☐Interdisciplinary Care Committee
☐Infection Control	☐Pharmacy & Therapeutics	☐Medical Staff Executive Committee
☐Information Services	☐Radiology	☐Click here to enter text
☐Laboratory/Pathology	☐Click here to enter text	

REFERENCES AND ACCREDITATION STANDARDS:	
Click here to enter text	
APPROVAL Click here to enter text **Vice President for Patient Services**	**APPROVAL** Click here to enter text **Director of School Health Services**

Original signature on file in School Health Services

PURPOSE:
The purpose of this policy is to explain medication administration guidelines for the School Health Services Department.

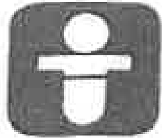
POLICY:
The safety of any and all students who receive medications while at school is the responsibility of the School Health Services employee during contracted clinic hours. It is the responsibility of the School Health Services staff to document all medication administered.

PROCEDURE:
Definitions and Policy Guidelines:

1. Registered Nurses/Licensed Practical Nurses: Medication may be administered in accordance with the State of Ohio Revised Code and Ohio Board of Nursing Rules for Nursing Practice.
2. Medical Assistant/Health Aides: Medical Assistants and Health Aides may administer medications as designated by the school district policy (ORC 3313.713). Medical Assistants and Health Aides may not accept verbal orders. Medication orders must be in written form and signed by the physician/healthcare provider within one week of receiving medication.
3. General Guidelines
    a. A registered Nurse reviews all medication orders. School clinic staff are required to inform the District RN of any new medications or change in physician/healthcare provider orders upon receiving.
    b. All prescription medications require a physician/healthcare provider order which includes the student's name, name of medication, the dosage, the time to be administered, the route the medication is to be given, the reason for the medication, a start and stop date.
    c. All medications must be given according to Individual School Board of Education policy.
    d. If Board of Education policy permits, over the counter medication may be given without a physician/healthcare provider order.
    e. The parent/guardian must provide written authorization for any medication to be administered at school.
    f. All prescription and non-prescription medications must be in the original container. Prescription medications must have pharmacy or physician/healthcare provider labels with the students name, the name of the medication, the dosage, route and time of administration.
    g. Narcotic prescription medications are not permitted to be given while at school without authorization from the District RN.
    h. All medication and medication forms must be brought to the school by the parent/guardian.
    i. Prescribed oral medications are to be counted by two adults and documented on the Medication Administration Record upon receipt from parent/legal guardian.
    j. All medication given during the school day will be documented on the individual student's Medication Administration Record (MAR) at the time given.
    k. Two forms of identification will be included on the MAR (ie. Student name and birth date). Include a small picture of the student on the MAR when available.
    l. All medications must be kept in a locked cabinet at all times.
    m. School Health staff will keep the cabinet keys with them at all times while on duty during the school day. The principal will designate school building personnel to hold the keys and administer medication in the absence of school health personnel.
    n. Students may self-carry and administer medications with the appropriate authorization from his/her physician/healthcare provider and parents and in accordance with school policy. The proper permission and medication forms must be on file for a student to self-carry and/or administer medication during the school day.
4. Over the Counter Medications
    a. Over the counter medication must be a Federal Drug Administration approved. Published information regarding appropriate pediatric dosages, indications, interactions and side effects must be available.
    b. There must be a Non-Prescription Medication Administration form signed by the parent/guardian on file.
    c. Medication must be in original unopened container.

d. If a child requires an Over the Counter Medication in school for more than four consecutive days a physician/HCP order is required to continue administering the medication. The clinic staff should report OTC use to the District RN.
e. Physician/HCP may permit a student to self-carry/self-administer a prescribed medication with signed HCP orders.
f. The requested dose must match the original container. If not, HCP signature is needed.
g. If an Over the Counter medication is given prior to lunch, clinic staff are required to call home to verify that no over the counter medication was given prior to coming to school. In the event that a parent/guardian is unavailable clinic staff should call the District RN for direction. If over the counter medication is requested after lunch a note and/or call home to parent/guardian stating medication was given is required. Document parent notification on MAR.
h. All other guidelines for Medication Administration apply.

5. Alternative/Homeopathic/Complementary/Herbal Therapies
    a. School Health Services employees shall not administer any substance in which safety is not established.
    b. All alternative therapies must be FDA approved with labeling that verifies safe pediatric dosage, indications, interactions and side effects.
    c. Other documentation required includes:
        - A written order from a healthcare provider authorized by the state
        - Identification of the condition for which the product is being used.
        - A Medication Administration form signed by the parent/guardian.
    d. Nothing in this policy shall stop parents/guardians from administering these medications to their child at school.
6. Medication Safety
    a. Students should be identified with 2 forms of identification before giving medication. If there is a question about student identity, confer with building personnel.
    b. The six rights must be maintained. The right medication should be given to the right student, at the right time, with the right dosage, the right route, and the right documentation on the Medication Administration Record.
    c. Always review the physician/HCP order before administering any medications.
    d. Medications should be prepared and administered one at a time. No pre-pouring.
    e. Medication should be poured into the child's hand from the container lid, medication cup or from the container.
    f. Never allow a student to retrieve his/her own medication from the cabinet.
    g. School Health personnel may not administer the first dose of any medication.
    h. Document all medications given on the MAR.
7. Medication Errors
    a. If a medication error is made, notify the District RN immediately. Notify the building principal and parent/guardian. The District RN will initiate appropriate medical action, complete Safety Event Reporting form and notify Nurse Manger.
    b. Medication errors consist of:
        - Wrong dose
        - Wrong student
        - Wrong medication
        - Wrong time
        - Wrong route or method of giving medication
        - Lack of documentation of medication given
        - Incorrect medication counts
        - Not giving a medication



SCHOOL HEALTH SERVICES

Attach Student Picture If available

Prescription Medication Administered at School

School: ______________________

School Year: ____________

Class/Grade: __________

Student Name: ____ D.O.B.: ______________

Student Address: ____

To Be Completed by Physician/Healthcare Provider:

Name of medication: ____________________________________ Dose: ______________

Time to be given: ______________________ (during school hours)

Reason for medication: ____

Form of medication: ___Tablet ___Liquid ___Inhaler ___Nebulizer ___Other

Start Date: __________ Stop Date: __________

Special Instructions: ____

Potential adverse reactions to be reported: ___________________________________

____

Physician/Healthcare Signature: _______________________________ Date: __________

Physician/Healthcare Provider Name: ____
Print Name

Phone: ____________________________________ Fax: ______________________________

<u>Parent/Guardian:</u> I give permission for my child to receive this medication at school according to the school district policy and as instructed by my healthcare provider.

I agree and am responsible to:

- **Deliver my child's medicine to school in its original container and labeled by a pharmacist or healthcare provider**
- **Tell the school as soon as possible if there is a change in the use of my child's medicine**
- **Tell the school if my child gets a new healthcare provider**
- **Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes.**

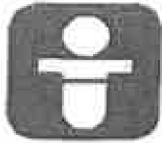
I agree for child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.

Parent/Guardian Signature: ____________________________________ Date: ______________

Parent/Guardian Phone: ______________________ Emergency Alternate Phone: ______________

THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR

Clinic Use Only: Date form received __________ Date medication received: __________ Form Complete (Y or N) _____
Notes: ____ Date Form complete: __________



SCHOOL HEALTH SERVICES

Non-Prescription Medication Administered at School

(Any medication that is purchased over the counter)

Attach Student Picture If available

School: ______________________

School Year: ______________

Grade/Class: ______________

Student Name: ______________________________ Date of Birth: ______________

Student Address: ____

Name of Medication: ______________________________ Dose: ______________

Time to be given (during school hours): ______________________________

Reason for Medication to be administered: ______________________________

Form of Medication: _____Tablet _____ Liquid _____ Other

Start date: ______________ Stop date: ______________

Special Instructions: ____

Potential adverse reactions to be reported to parent or physician: ______________________________

____

Physician/Healthcare Provider Name: ______________________________ Phone: ______________

Parent/Guardian: **I give permission for my child to receive this medication at school according to the school district policy. I agree and am responsible to:**

- **Deliver this medicine to school in its original container.**
- **Tell the school as soon as possible if there is a change in the use of this medicine.**
- **Tell the school if my child gets a new healthcare provider.**
- **Complete a new medicine form for this medicine if there are dose changes.**

Medication dosage outside of the dose indicated on bottle for the child's age requires a health care provider order. If this medication is needed for greater than 4 consecutive days, I understand that a healthcare provider order is required.
I agree for child's healthcare provider to talk with the school or any school staff person about this medication if needed. No other part of my child's medical health will be discussed. When my child receives this medication I will be notified.

Parent/Guardian Signature: ______________________________ Date: ______________

Parent/Guardian Phone: ______________________ Emergency Alternate Phone: ______________________

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR****

Clinic Use Only. Date form received __________ Date medication received: __________ Form Complete (Y or N) _____

Notes. ______________________________ Date Form complete: __________

7/09, 4/10, 6/12, 5/13, 6/14, 6/15