ST. PATRICK'S
EPISCOPAL CHURCH & DAY SCHOOL

MEDICATION ADMINISTRATION POLICY

PAGE 14 OF THE ST. PATRICK'S PARENT HANDBOOK

If a child requires any medication while in our care, the parent/guardian must complete a Medication Authorization Form and bring the form, along with the medication, to our front office.

The Medication Authorization Form shall include:

- Child's full name
- Medication Type: Daily, As Needed, and/or Emergency Use
- Medication name and strength
- Date(s) to be administered
- Directions for use:
  > Route (oral, topical)
  > Dosage
  > Frequency
  > Time to be given
  > Schedule
  > Special instructions, if any
- Possible Side Effects/Anticipated Reactions
- Signature of parent and date of signature

Requirements for medication container/packaging:

- **Prescription Medication** is required to be in the original pharmacy container with the complete pharmacy label.
- **Non-Prescription Medication** is required to be in the original bottle packaging for the medication, which shall include the drug name, strength, and clear directions for use.
  ◊ If a non-prescription medication label reads, "consult a physician," written authorization from a licensed health care provider will be required to accompany the medication.

All medication must be clearly labeled with the child's first name, last name, and the medication's expiration date. Medication shall not have an expired date. *We cannot administer expired medication under any circumstance.*

All medication*, oral and topical including but not limited to: diaper ointments, creams, lotions, sprays, powders, gas drops, Vaseline, etc.,* **must be kept in a locked location**; either within the child's classroom or our front office. We cannot allow these items to be stored in diaper bags or backpacks.

Children who require **As Needed** or **Emergency Medications**, such as but limited to: an EpiPen, Benadryl, an inhaler, breathing treatments, etc.., shall have an attached 'Written Plan of Action' from a licensed healthcare provider and must include:

- Child's name
- Medication name and strength
- Method of administration
- Circumstances for administrating 'As Needed' medication and/or Symptoms that indicate the need for 'Emergency' medication
- Actions to take once symptoms occur
- Description of how to use the medication
- Any applicable special instructions
- Signature of provider and date signed
- Signature of parent and date signed

All Medication Administration Forms shall be updated every six months or as needed.

When a parent administers medication to his/her own child on center premises, the medication administration shall be documented in our Medication Administration Log and signed by the parent administering the medication or staff member witnessing the medication administration.

St. Patrick's
EPISCOPAL CHURCH & DAY SCHOOL

AUTHORIZATION TO GIVE EMERGENCY MEDICATION

THIS PAGE IS TO BE COMPLETED BY PARENT/GUARDIAN OF STUDENT

CHILD'S FULL NAME: _____

This medication is to be administered FOR EMERGENCY USE ONLY

Medication Name* & Strength: _____

Dosage Amount/ Frequency: _____

————-PLAN OF ACTION ————————————————————————————-

How to be given: o Oral o Topical o With Meal o Before Meal o With Water
o Refrigerate o Shake Well o Other:_____

Special Instructions, if any:_____

Possible Side Effects/Anticipated Reactions: _____

_____

Symptoms indicating need for Emergency Medication: _____

_____

Actions to Take Once Emergency Symptoms Occur: _____

_____

————-MEDICATION ADMINISTRATION 'SAFETY CHECKLIST' ITEMS————————————--

Please initial by each safety checklist item below:

_____ 1. **Prescription medication*** is in the original pharmacy container with complete pharmacy label or **non-prescription medication*** is in the original manufacture's bottle packaging for medicine.

_____ 2. Medication* is accompanied by information indicating child's name, prescribing physician, medication name, dosage, route, times to be given, duration to be given, pharmacy's name and phone number, issue and expiration date. (If prescription, pharmacy label or if non-prescription, written authorization from a licensed health care provider)

_____ 3. Medication* is not expired.

_____ 3. Medication* is clearly labeled with the name of the child above.

_____ 4. Administration instructions above are filled out completely.

_____ 5. Parents instructions match pharmacy or physician's instructions.

_____ 6. Medication* is handed to Director, Assistant Director, or Staff-in-Charge at St. Patrick's.

_____ **I understand that this medication* will be given according to the above directions, and that in any changes occur I must inform the staff and fill out a new form.**

_____ **I understand that this Authorization to Give Medication Form must be updated as needed or every 6 months from date this form is signed.**

Parent's Name *please print*: _____ **Phone Number:** _____

Parent's Signature: _____ **Date:** _____

Signature of Staff who reviewed information with parent: _____

This form expires on _____ *(6 months from today or last date to be given)*

St. Patrick's
EPISCOPAL CHURCH & DAY SCHOOL

EMERGENCY MEDICATION ADMINISTRATION RECORD

This medication is to be administered FOR EMERGENCY USE ONLY

INSTRUCTIONS FOR ADMINISTRATION:

1) **See attached Written Plan of Action for physician's instructions.**
2) Verify the 6 Rights: Right child, Right medication, Right time, Right dose, Right route, Right child.
3) Wash Hands.
4) Administer medication according to instructions.
5) Return medication to secure storage location.
6) Wash hands.
7) Record information above and sign.
8) Contact Parent/Guardian Immediately.

CHILD'S FULL NAME: _____

DATE ADMINISTERED: _____

TIME ADMINISTERED: _____

Symptoms that indicated the need for the medication: _____

_____

Actions taken once symptoms occurred: _____

_____

Description of how medication was administered: _____

_____

_____

_____ _____

Name of Parent/Guardian Contacted via Phone | Phone Number of Parent/Guardian

_____ _____

Name of Staff Member Administering Medication | Name of Staff Member Who Contacted Parent/Guardian

_____ _____

Signature of Staff Member Completing Form | Date