



MEDICATION ADMINISTRATION PROCEDURE FOR PARENTS

The following procedures are in line with the current federal and state requirements for medication administration in all school types.

Definitions:

“Medication” includes both prescription and non-prescription medications, including those taken by mouth, taken by inhaler, which are injectable, applied as drops or ointment to the eye or nose, applied to the skin, or any other form prescribed by a physician. These include over-the-counter (OTC) medications such as pain relievers, cough suppressants (including cough drops), nasal decongestants, upset stomach medications, medicated lotions, etc. excluding OTC topical antibiotics (ex: Neosporin).

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1. Medications administered at school shall be restricted to only medication that must be administered during the school day. [Parents/guardians should administer medications at home when possible.](#)
2. Parents/guardians should complete the Consent for Medical Treatment Form (Form MED-2).
3. Permission to Apply (Form MED-3) may be completed to give consent for the application of sunscreen, insect repellent, topical antibiotic, lip balm, and hand sanitizer.
4. The first dose of a newly prescribed medication may not be administered at school. Parents must let the Medication Administration Monitor know when the first dose of a new medication is given and communicate any potential side effects.
5. All medications may only be administered by trained staff. Medications will be kept in a locked cabinet at all times. Expired medications will be returned to parents within one month of expiration. GCS will not administer expired medications.
6. A Medication Administration Authorization Form (Form MED-4) must be signed by the student's licensed medical practitioner for the administration of each prescribed or over the counter (OTC) medication, including cough drops and other medical remedies, during school hours and at school-sponsored events, including off-campus events. The Medication Administration Authorization Form (Form MED-4) shall be renewed annually

and signed by the licensed prescriber. Changes in the order or discontinuation of the order must be in writing from the licensed prescriber. Written instructions from a physician, which includes the name and birthdate of the student, name of the medication, dosage of the medication, route of administration, and the time the medication is to be administered to the pupil shall accompany the request and be kept on record by the school. A separate Medication Administration Authorization Form (Form MED-3) must be on file for each medication.

7. Medication must be delivered to authorized personnel by a responsible adult (whenever possible, a parent) in an original pharmacy labeled container or unopened manufacturer's package. Medication may not be delivered directly by the student. Medication is counted and documented on the Medication Administration Log (Form MED-9) upon receipt. This document will then be signed by the school staff member and adult delivering the medication.

8. Any changes to the medication dosage or time of administration will not be made without written instructions from the physician or authorized prescriber after the initial request.

9. Parents/Guardians are responsible for resupplying all medications. Grace Christian School will not supply any medications to students for any reason. All medications for students must be supplied by the parents and must have the required Medication Administration Authorization Form (Form MED-4) in order to be administered to the student.

10. All medications left at the end of the year must be picked up by the parent/guardian within one week of the end of the school year. All medications left after this will be discarded or destroyed per local ordinances.

11. If a student has an adverse reaction to the medication, we will notify parents immediately. We will also call 911 if the reaction is severe.

12. Students may self-carry emergency medications if the following requirements are met:

- a. The parent/ guardian understands that medication may be given without supervision.
- b. The parent/guardian and the prescribing physician have determined the student is capable of self-carrying and will be responsible with the medication.

- c. The prescribing physician has signed the Medication Administration Authorization Form (Form MED-4) allowing the student to self-carry. The Form must specifically state that the student may self-carry.
- d. The student's teachers must be made aware that the student is self-carrying medication. The teachers must also be given training in case the student is unable to self-administer the medication.
- e. Any misuse of medication that violates the policies- such as irresponsibility, selling of medication, mishandling of medication, or giving away of medication- will result in revocation of self-carry permissions. Building administration may disallow self-carrying abilities if it is deemed necessary for the safety of the student population. Parents/guardians and the prescribing physician will be notified immediately if self-carry permissions are withdrawn.
- f. Emergency Medication Self-Carry and Self-Administration Care Plan (Form MED-5) must be completed for each emergency medication that a student is self-carrying. This plan must include how the student will record self-administration and when the student must seek assistance. For emergency auto-injectors, see point g.
- g. The Food Allergy & Anaphylaxis Emergency Care Plan (Form MED-6) must be completed by a healthcare provider when a student is self-carrying an emergency auto-injector.



CONSENT FOR MEDICAL TREATMENT FORM

2023/2024

Child's name	DOB	Grade	Allergies	Dr name and phone number	Insurance Co & Policy #

I, the parent or guardian of above listed students, give my permission to Grace Christian School to seek medical treatment with a licensed doctor, physician, or emergency treatment center to administer the necessary attention and aid IMMEDIATELY to my child should he/she become injured or sick while participating in a school sponsored event.

Examples of these emergencies include, but are not limited to:

- Fainting/unconsciousness
- Anaphylaxis
- Severe allergic reactions
- Bodily injury
- Any other incident that would require treatment beyond basic first aid

I understand that every effort will be made to reach me should the nature of the injury or illness warrant it. I agree to release from liability and hold harmless all school personnel and Grace Christian School.

Parent signature _____ Date _____



**PERMISSION TO APPLY
SUNSCREEN, INSECT REPELLANT, and OTC TOPICAL
ANTIBIOTIC, LIP BALM, AND HAND SANITIZER**

I, _____, the parent/guardian of _____
_____ give permission to Grace Christian School to administer the following items as
needed:

1. Sunscreen

Parent provided sunscreen (labeled with child's name) or school provided sunscreen 30
spf or higher (generic brand)

As directed on the label by manufacturer of such product.

2. Insect Repellant

Parent provided bug spray (labeled with child's name) or school provided bug spray
(generic brand)

As directed on the label by manufacturer of such product.

3. Over the counter topical ointment (generic Neosporin, triple antibiotic)

Parent provided topical ointment (labeled with child's name) or school provided topical
ointment (generic brand)

* Reason to apply the ointment: minor cuts and scrapes and eczema related wounds

As directed on the label by manufacturer of such product.

4. Parent Provided Lip Balm:

* Reason to apply: chapped lips

As directed on the label by manufacturer of such product.

5. School Provided Hand Sanitizer/Alcohol Wipes:

* Reason to apply: to sanitize hands after coughing or sneezing or to clean a wound.

As directed on the label by manufacturer of such product.

Parent's signature: _____ Date: _____



MEDICATION ADMINISTRATION AUTHORIZATION FORM

2023/2024

Medication must be delivered to school by a responsible adult (whenever possible, a parent) in the original pharmacy labeled container or unopened manufacturer's package. Medication may not be delivered directly by the student. Medication is counted and documented upon receipt and signed by the school staff member and adult delivering the medication. This form must be renewed annually and must be signed by a non-parent, licensed prescriber.

LICENSED PRESCRIBER'S AUTHORIZATION

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____

Dose: _____ Route: _____ Time(s): _____

If PRN, frequency: _____ If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title _____

Telephone: _____ FAX: _____

Address: _____

Licensed Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that within one week of the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school administration to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home #: _____ Cell #: _____ Work #: _____

EMERGENCY MEDICINE SELF CARRY/SELF ADMINISTRATION AUTHORIZATION

Student may self-carry this emergency medication. (must be signed by prescriber and principal)

Licensed Prescriber's Signature _____

Principal's Signature _____ Date _____

I understand point 12e of the Medication Administration Parent Procedure (Form MED-1) and agree to abide by it.

Student's Signature _____ Date _____



EMERGENCY MEDICATION SELF-CARRY AND SELF-ADMINISTRATION CARE PLAN

2023-2024

I, _____, agree to keep record of when I self-administer my medication. I understand that I may need to share this record with my parents or the Medication Administration Monitor if requested.

Medication name _____

Dosage _____

Time to be taken _____

In the event that I am unable to self-administer my medication, students and staff around me should _____

911 should be called if _____

Student signature _____ Date _____

Parent signature _____ Date _____

Teacher signature _____ Date _____

Teacher signature _____ Date _____

Teacher signature _____ Date _____

Teacher signature _____ Date _____

Teacher signature _____ Date _____

Teacher signature _____ Date _____

Teacher signature _____ Date _____

Teacher signature _____ Date _____

Teacher signature _____ Date _____

Name: _____ D.O.B.: _____

Allergic to: _____

 Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

**PLACE
PICTURE
HERE**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

- ☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- ☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

**OR A
COMBINATION**
of symptoms
from different
body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE
SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM
AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

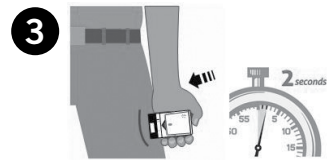
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

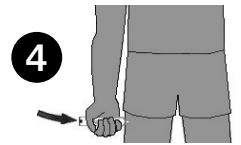
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



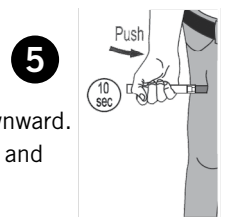
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____