PITTSYLVANIA COUNTY SCHOOLS
P. O. Box 232, 39 Bank Street, SE, Chatham, VA 24531
Dr. Mark R. Jones
Division Superintendent

MEDICATION PROCEDURE

Parents are expected to give medications at home on a schedule other than during school hours if at all possible. No medication may be taken by a student at school except as herein provided. This procedure will provide safety, consistency, and confidentiality when it is necessary that a medication be taken during school hours.

GENERAL GUIDELINES FOR ALL MEDICATIONS

1. Medications given/prescribed once, twice, or three times daily should be given at home.
2. Parent/guardian permission is required for any medication taken by a student.
3. **All medications are required to be presented to the school office by an adult. It is the parent's/guardian's responsibility to consult with the school nurse in person or by phone regarding any medication. Failure to follow the medication procedure protocol may result in disciplinary action in accordance with the Student Code of Conduct.**
4. All medications must be presented in the original container labeled with the student's name, date, and name of medication. If there is any discrepancy, whatsoever, between the label on the bottle, the parent's/guardian's instructions, or the doctor's order (if indicated), the student will not be allowed to take the medication.
5. When the parent/guardian has completed Section B of the Medication Permission Form (SHS-1), medication is in a properly labeled container, and a physician has completed Section A of the Medication Permission Form (SHS-1) (if indicated), the student may take the prescribed dose of medication. **Medicine must be taken in the presence of a designated adult** and documented on the medication log. **All medications are to be kept locked up with limited access by designated adults with the exception of Inhalers and EpiPens.**
6. In the absence of a school nurse, the principal or designee will be responsible for assigning a trained staff member to assist students taking medication and for periodic monitoring of the Medication Procedure.
7. The Medication Permission Form (SHS-1) must be updated at the beginning of each school year and when there is a change of dosage.
8. Medication not picked up at the close of the school year (or sooner if indicated) will be destroyed. Reminder by letter or telephone call to the parent/guardian for medications(s) to be picked up will be made before the close of the school year (or sooner if indicated).
9. Exceptions to these procedures may be necessary depending on individual circumstances.
10. If you have any questions regarding this procedure, please call the nurse at your child's school.

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CHRONIC MEDICATIONS

These are prescription medications taken by a student throughout the school year. Examples in this category are medications prescribed for asthma, ADD/ADHD, seizures, ulcers, migraines, diabetes, and emergency situations.

- Sections A and B of the Medication Permission Form (SHS-1) must be completed.
- The medication must be in the original prescription container.
- Certain medications (i.e. inhalers and Epi-pens) may be kept with the student for emergency use. The school nurse will have **additional documentation**, which is mandatory, before a student will be allowed to carry his/her own emergency medication. The principal's signature giving authorization is required.

ACUTE MEDICATIONS

These are prescription medications taken by the student on a short-term basis during the school year (i.e. antibiotics).

- Section B of the Medication Permission Form (SHS-1) must be completed.
- Section A of the Medication Permission Form (SHS-1) must also be completed if the prescription is to be taken for longer than **two weeks**. Any medication not taken during this two week period will be discarded if not picked up by the parent/guardian.
- The medication to be taken at school should be labeled by the Pharmacist in a separate container from that to be taken at home. (This prevents transporting a medication back and forth daily.)

OVER-THE-COUNTER MEDICATIONS

These are medications purchased over-the-counter for short-term treatment of minor illnesses. Examples in this category are cough syrups, cough drops, cold remedies, and pain relievers. Any over-the-counter medication must be in the original container and labeled with the student's name. Non-prescription medication must be appropriate for the student's age and weight, according to package directions.

- Section B of the Medication Permission Form (SHS-1) must be completed.
- Section A of the Medication Permission Form (SHS-1) must be completed for medication which is taken for more than **three** consecutive school days, contains aspirin (acetylsalicylate, salicylic acid or salicylate) or is herbal/homeopathic.
- Requests for cough and cold remedies to be given will be effective for **one week**. After that time, medication not taken or picked up will be discarded.

SELF-ADMINISTRATION OF MEDICATION

Sharing, borrowing, distributing, manufacturing or selling any medication is prohibited. Permission to self-administer prescription or non-prescription medication may be revoked if the student violates this policy and the student may be subject to disciplinary action in accordance with the Standards of Student Conduct.

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MEDICATION PERMISSION FORM

I. ALL medications taken at school require:

1. Parent/Guardian signature on Medication Permission Form (Section B).
2. Original container.
3. Explicit directions on the dosage and time medication is to be taken.

II. A doctor must complete Section A of the Medication Permission Form for medications prescribed:

1. On a daily basis.
2. "As needed" for treatment of chronic illnesses.
3. For treatment of emergencies.
4. That contain aspirin (acetylsalicylate, salicylic acid or salicylate).
5. That are herbal/homeopathic.

III. ALL MEDICATION MUST BE BROUGHT TO THE SCHOOL BY A PARENT/GUARDIAN.

SECTION A: **PHYSICIAN'S ORDERS**

Student's Name _____ Date of Birth _____ School _____

Medication _____ Dose _____ Time _____

For treatment of _____

Adverse reactions expected _____

_____	_____	_____
Physician's Signature	Print Physician's Name	Date
_____	_____	_____
Fax Number	Telephone Number	NPI Number

SECTION B: **PARENTAL/GUARDIAN CONSENT**

Student's Name _____ Date of Birth _____ School _____

Grade _____ Homeroom Teacher _____ Pediatrician _____

Parent/Guardian Name _____ Cell (_____)_____ Alternate (_____)_____

I hereby request and authorize you to allow my child to take:

Medication _____ Dose _____ Time _____

I release school personnel from liability should reactions result from this medication. I authorize a representative of the school to share information regarding this medication with the above doctor.

_____	_____
Parent/Guardian Signature	Date

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