

ADMINISTRATION OF MEDICATION
REGULATIONS MANUAL

(to accompany Policy 3D:4 – Management of Students’ Medical Needs in the School)

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- Section G Ministry of Education – Policy/Program Memorandum #81
Model for provision of School Health Support Services

A. Definitions

1. Medically at Risk Student

A medically at risk student is a student with a medically diagnosed, predetermined health condition who may experience a life-threatening event which would require immediate action.

2. Administration

“Administration” for the purpose of policy 3D:4 means:

- Actual administration of the medication if appropriate or necessary
- Visual supervision and observation of the taking of the medication
- Safe storage and handling of the medication
- Recording of the administration of medication on the approved form

3. Prescription Medication

Prescription medication includes any medication that is prescribed by a licenced medical practitioner. The use of prescription medication is discouraged for use at school, however, the Board recognizes that on occasion there may be the need for students to receive medication during the school day in order to enable education of the student to continue.

4. Non-Prescription Medication

Non prescription medication includes any medication that is not prescribed by a licenced medical practitioner such as aspirins, ointments, creams, cough syrups, cough drops, etc.

Board personnel shall not administer “non-prescription medication” to students.

B. Injection Medication

If injection medication is required, the arrangement for the injection of medication shall be made by the parents/guardians. School personnel shall assume no responsibility for injections (e.g. juvenile diabetic requiring mid-day insulin). However, staff may not refuse to administer potentially life-saving medication, as with an Epi-Pen® (see Policy 3D:12).

C. Student Self-Administration of Prescribed Medication

1. The principal shall notify parents/guardians of their responsibility to inform the school when a child is self-administering medication.
2. The principal shall keep a record of those students in the office.
3. The principal shall contact parent/guardian if he/she has concerns about the student's ability to safely administer or store prescribed medication

D. Staff Administration of Prescription Medication Procedural Regulations

In order for prescribed medication to be administered parents/guardians shall provide the necessary authorizations and school administrators shall abide by the following regulations.

1. Prescription drugs shall be administered to students under the following conditions:
 - **Short Term Illness – less than six weeks**
Specific written and signed direction from the parent/guardian shall be acceptable.
 - **Long Term Illness – six weeks or more**
Receipt of signed authorization from the parent/guardian and attending physician shall be required (see Forms 3D:4-B and 3D:4-C).
2. For either short term or long term illness, prescription drugs shall be hand delivered by the parent/guardian to the principal or designate. The designate shall inform the principal as soon as possible.
3. Prescription drugs must be packaged in the original container as supplied by a pharmacist. The package must be clearly labeled with:
 - i) The child's name
 - ii) The name of the drug
 - iii) The date of purchase
 - iv) Instructions for storage
 - v) Specific directions for administration (Do **not** administer if the instructions read "administer as required")
 - vi) Prescribing physician's name
4. All consent forms, including the attending physician's written instructions in the case of a Long Term Illness, shall be maintained in the principal's office as well as provided to the person responsible for supervising and administering the medication.

5. For every child receiving medication, the telephone numbers of the parents and physician in the case of a Long Term Illness, must be readily available at school. Note: *It is the parents' responsibility to ensure that the school has the correct telephone numbers.*
6. Upon receipt of a completed form, including the signature of the prescribing physician in the case of a Long Term Illness, the principal shall:
 - i) Store the medication in a secured area as required;
 - ii) Establish and carry out a procedure for the administration of medication in a manner which allows for sensitivity and privacy and which encourages the student to take as much responsibility for his/her own medication as is appropriate and desirable;
 - iii) Ensure that appropriate records are maintained;
 - iv) Return any medication to the parent/guardian at the end of the school year or at the end of the prescription period. If unable to return to the parent/guardian, the principal shall request a local pharmacist to dispose of the remaining prescription.
7. Students requiring medication due to **asthmatic conditions** should be expected to be properly instructed by a physician and/or parent/guardian in the use of inhaled medication by the approximate age of eight (8). Thus, students of this age or older should carry their own personal medication on their person at all times. The appropriate medical form still must be completed. The physician should indicate on the **Attending Physician's Authorization Form – 3D:4-C** that the student is competent to carry and self-administer this medication.

A medical plan for those students younger than eight (8) should be developed by their physician and shared by the parent/guardian.

8. Requests for the administration of **insulin injections** at school require the completion of Form 3D:4-C. If students are of an age, as determined by a physician, to self-administer these injections, the physician should indicate on the **Attending Physician's Authorization Form – 3D:4-C** that the student is competent to self-administer his/her medication.

If students require assistance with the administration of insulin injections, the parents/guardians shall request their physician to contact the Community Care Access Centre and leave a standing order for the particular child who has a real need for a nurse to come to the school and administer the injection at lunchtime. Parents shall be expected to inform the school of the signs and symptoms indicating problems. All staff should be shown a photo of the student (especially at the elementary level) and informed of the possible symptoms.

Schools may supervise students during their blood sugar checks, record the findings and also provide a secure storage area for the insulin and syringes as well as safe disposal for the used needles.

Schools may contact their local Health Unit to invite a health care professional to a staff information session.

9. In emergency situations, the principal is to use his/her judgement in authorizing accredited ambulance services to transport the student to the nearest medical facility.

E. Responsibilities

<i>Role of the Parent/Guardian</i>	<i>Role of the School</i>
1. Notify the school principal that the child requires or may require medication.	1. The principal shall send the Detailed Medical Information Form (3D:4-B) to the parent/guardian.
2. Complete the Detailed Medical Information Form (3D:4-B) and have physician complete the Attending Physician Authorization Form (3D:4 -C)	2. The principal shall ensure that the form Detailed Medical Information Form (3D:4-B) is completed for the student prior to the administration of medication.
3. Supply medication in original container as prescribed by the attending licenced medical practitioner.	3. The principal is responsible for deciding if a Medical Plan is necessary. If deemed necessary, the principal shall in collaboration with the parent/guardian and, if necessary, members of the medical community, devise a Medical Plan.
4. Provide the school with a description of the medication outlining any side affects (this information is readily obtained from the pharmacist).	4. The principal shall ensure the medication is clearly labeled for each student in the original container, has clearly indicated dosages, and is securely stored to ensure administration to the correct student and to avoid loss or tampering. The principal shall inform the appropriate staff members about the medical needs of the student. If a Medical Plan is deemed necessary, staff members shall be informed of the medical needs of the student and the intervention outlined in the Medical Plan.
5. Delivery of prescribed medication to the principal.	5. The principal shall maintain the <i>Individual Student Log of Prescription Medication Administered</i> (Form 3D:4-D) or designate a staff member to maintain it. Each student shall have an individual log maintained. A copy of the record shall be made available for parents upon request.
6. Changes in dosage and administration must be communicated immediately to the school..	6. The staff person administering medication to the student shall maintain the Individual Student Log of Prescription Medication Administered Form (3D:4-D) On dates when the student is absent, the log should reflect such student absence. The “comments” section should reflect abnormal or unusual circumstances related to such administration. The monthly log sheet is to be kept on file by the principal with the Detailed Medical Information Form.

<i>Role of the Parent/Guardian</i>	<i>Role of the School</i>
7. Notify the school when a child is self-administering medication.	7. Assistance in training to administer medication is the responsibility of the parent in conjunction with the principal. Assistance or advice should be sought from the licenced medical practitioner or the Health Unit if necessary.
	8. The principal shall ensure that staff members who undertake the responsibility of administering medication or intervening in a medical situation with a student who has chronic health needs shall have at least a minimal background understanding of the medical situation and have received specific direction and training in order to perform their role.
	9. The principal shall be responsible for completing the section in the O.S.R. indicating medical needs.
	10. The student shall take the medication in the presence of the person responsible for the administration of the medication.
	11. The principal shall ensure that the medication is administered in a manner which allows for sensitivity and privacy and which encourages the student to take an appropriate level of responsibility of his/her medication.

F. Forms related to the collection of medical information and monitoring medical needs of medically at risk students:

- Early Years Entry Form
- School Information Form
- Letter to Parents/Guardians for Students with Medical Conditions Form (3D:4-A)
- Detailed Medical Information Form (3D:4-B)
- Attending Physician Authorization Form (3D:4-C)
- Individual Student Log of Prescription Medication Administered Form (3D:4-D)



Huron-Perth Catholic District School Board

Mail PO Box 70 Dublin ON N0K 1E0 Phone 519 345 2440 Fax 519 345 2449 Website www.hpcdsb.edu.on.ca

EARLY YEARS ENTRY INFORMATION FORM

Dear Parent/Guardian:

By completing the following questionnaire you can assist us in providing the best learning environment for your child. However, completion in part, or in whole, is your choice.

_____ M ____ F ____
Child's Surname Given Names Date of Birth (Y/M/D)

Address _____

Parent's Name(s) _____

Language spoken at home _____

Child lives with: Both Parents ____ Mother ____ Father ____ Other ____

HEALTH HISTORY

1. Does your child suffer from allergies? Yes ____ No ____ Please list allergies and severity of reaction.

2. Does your child suffer from other medical problems? Yes ____ No ____ Please describe problem and severity. _____

3. Please list any disabilities and special needs of which the teacher should be aware. _____

4. Does your child take medication? Yes ____ No ____ Describe: _____

5. Has your child had an assessment for:

➤ Vision: Yes ____ No ____ By Whom: _____
Results _____

➤ Hearing: Yes ____ No ____ By Whom: _____
Results _____

➤ Speech Yes ____ No ____ By Whom: _____
Results _____

DEVELOPMENTAL HISTORY

1. Describe any concerns you have about your child in the following areas:

Speech and language development _____

Motor development (e.g. running, balance, accident prone) _____

Eating habits (eg. slow eater, snacks frequently) _____

Sleeping habits (eg. regular nap, nightmares, up at night) _____

Toilet habits (eg. daytime accidents) _____

Other _____

SOCIAL & EMOTIONAL HISTORY

1. Which type of play does your child like the best?
playing alone ____ watching others play ____ playing actively with others ____
2. Does your child have regular opportunities to play with other children? Yes ____ No ____
3. What responsibilities does your child have at home? _____
4. What are your child's favourite activities? _____
5. Does your child spend time looking at books on his/her own? Yes ____ No ____
6. Does your child enjoy listening to stories? Yes ____ No ____
7. Please explain any particular fears which your child may have. _____

8. When upset, does your child: like to be comforted ____ prefer to be left alone ____ Other _____

9. When angry, does your child: withdraw ____ seek out an adult ____ cry ____ retaliate ____
Other _____
10. When frustrated, does your child: accept the frustration ____ sulk ____ cry ____ have tantrums ____
strike out ____
11. When corrected, does your child: accept the correction ____ cry ____ talk back ____ withdraw ____
12. Describe the method of discipline to which your child best responds _____

13. What type of child care does your child receive?
Parent ____ Nursery School ____ Day Care ____ Babysitter ____

I hereby give consent for the school to share the above information with those involved in the education of my child, including the appropriate health care professional.

Signature of Parent/Guardian completing questionnaire

Date

***THANK YOU FOR FILLING OUT THIS QUESTIONNAIRE.
PLEASE RETURN IT TO THE SCHOOL WHEN YOU REGISTER YOUR CHILD.***



Huron-Perth Catholic District School Board

Mail PO Box 70 Dublin ON N0K 1E0 Phone 519 345 2440 Fax 519 345 2449 Website www.hpcdsb.edu.on.ca

SCHOOL REGISTRATION FORM

Dear Parent/Guardian:

By completing the following questionnaire you can assist us in providing the best learning environment for your child.

_____ M ____ F ____
Child's Surname Given Names Date of Birth (Y/M/D)

Address _____

Parent's Name(s) _____

Language spoken at home _____

Child lives with: Both Parents ____ Mother ____ Father ____ Other ____

HEALTH HISTORY

1. Does your child suffer from allergies? Yes ____ No ____ Please list allergies and severity of reaction.

2. Does your child suffer from other medical problems? Yes ____ No ____ Please describe problem and severity. _____

3. Please list any disabilities and special needs of which the teacher should be aware. _____

4. Does your child take medication? Yes ____ No ____ Describe: _____

5. Has your child had an assessment for:

➤ Vision: Yes ____ No ____ By Whom: _____

Results _____

➤ Hearing: Yes ____ No ____ By Whom: _____

Results _____

➤ Speech Yes ____ No ____ By Whom: _____

Results _____

I hereby give consent for the school to share the above information with those involved in the education of my child, including the appropriate health care professional.

Signature of Parent/Guardian completing questionnaire

Date

(School Letterhead)

Letter to Parents/Guardians for Students with Medical Conditions:

Date:

Dear *(Parent/Guardian)*

You have noted on the Student Registration/Student Information Form that *(name of student)* has an identified health issue. In order to have the most current information regarding your child's health, we are requesting that you complete the **Detailed Medical Information Form** and have your child's physician complete the **Attending Physician's Authorization Form**.

Personal information on the forms will help ensure that measures are taken to reduce the chance of your son/daughter experiencing a medical emergency at school. Should such an emergency occur, the information will allow us to take prompt and correct action to ensure your child's safety. The information **will be shared with school and relevant health personnel** and kept in a central location where it can be obtained quickly, if the need arises.

If there are changes in your child's medical information or treatment plan, please notify the school immediately.

If no medical response is required by the school, please complete the form below and return to the school as soon as possible.

Please feel free to contact me if you have any questions or concerns.

Respectfully,

Principal

Student Name: _____

No medical response is required by the school

Parent Signature: _____

Date: _____



DETAILED MEDICAL INFORMATION FORM

FORM 3D:4-B

STUDENT PHOTO

(required for life-threatening condition)

School Year _____

Student's Name _____

Date of Birth _____

School _____

Grade _____

Room # _____

Homeroom Teacher _____

Principal _____

EMERGENCY CONTACT NUMBERS:

NAME	PHONE #	RELATIONSHIP TO CHILD

Section A:

Medical condition _____

Is medication required for this condition? Yes No (If yes, please complete Section B)

Section B:

Administration of Medication: Prescription Supervision of student's self-administration of medication

TYPE

SCHEDULE

- Oral
- Inhaled
- External
- Injected (Epi-pen®, Epi-pen Jr.®)
- Other (specify) _____

- Short-term (specify) _____
- Trial (specify) _____
- On-going
- Emergency

Expiry date for medication, if applicable: _____

Is refrigeration for medication required? Yes No

Note: Expiry date is of particular importance for emergency use which is stored for long periods (i.e. Epi-pen®).

Child wears MedicAlert™

Bracelet

Necklace

Date

Parent/ Guardian Signature



ATTENDING PHYSICIAN'S AUTHORIZATION FORM

Name of Child: _____ Date of Birth: _____ School Year: _____
(yy mm dd)

1. Administration of Prescription Medication: Short term Long term
(under 6 weeks)

- Must be administered by school personnel
- Must be supervised by school personnel when administered
- Self administers, no supervision required

Name of Drug: _____ Instructions for Storage: _____

Specific Directions for Administration:

2. Medical Condition of Child:

Asthma Diabetes Seizures Other: _____
(Please specify)

Allergies (please list) _____

Anaphylactic Conditions _____

Physician's statement for health care assistance during school hours: _____

3. Emergency Response Plan for Condition:

Symptoms of reaction: _____

Recommended response to reaction: _____

Name of Physician: (please print) _____

Telephone: _____

Signature of Physician: _____

Date: _____

**G. Ministry of Education – Policy/Program Memorandum #81
Model for Provision of School Health Support Services**

Support Service	Administered By	Provided By	Training and Direction	Consultation
Oral Medication	Student as authorized	Student	Attending physician	Local Board of Health
	Or Parent as authorized	Parent	Attending physician	Local Board of Health
	Or Aide or other personnel	School Board	School Board/ Physician	Local Board of Health
Injection of Medication	Student as authorized	Student	Attending physician	Local Board of Health
	Or Parent as authorized	Parent	Attending physician	Local Board of Health
	Or Health professional	Ministry of Health	Ministry of Health	School Board
Catheterization Clean intermittent	Student as authorized	Student	Parent	Ministry of Health
	Or Aide or other personnel	School Board	Ministry of Health	Ministry of Health
Sterile Intermittent	Health professional	Ministry of Health	Ministry of Health	Ministry of Health
Manual Expression of Bladder/Stoma	Health professional	Ministry of Health	Ministry of Health	School Board
Suctioning Shallow Surface (e.g. oral or nasal suction)	Aide or other personnel	School Board	Parent or Ministry of Health	Ministry of Health
Deep (e.g. throat and/or chest suction or drainage)	Health professional	Ministry of Health	Ministry of Health	Ministry of Health
Tube Feeding	Health professional	Ministry of Health	Ministry of Health	School Board
Lifting and Positioning Assistance with Mobility Feeding Toiletting	Aide or other personnel	School Board	School Board Ministry of Health	Ministry of Health
	Aide or other personnel	School Board	School Board Ministry of Health	Ministry of Health
	Aide or other personnel	School Board	School Board Ministry of Health	Ministry of Health
	Aide or other personnel	School Board	School Board Ministry of Health	Ministry of Health

Support Service	Administered By	Provided By	Training and Direction	Consultation
Therapies a) Physio/Occupational Intensive Clinical	Qualified therapist	Ministry of Health	Ministry of Health	Ministry of Health
	General maintenance exercises	Aide or other personnel	School Board	Ministry of Health
b) Speech Speech Pathology (Treatment)	Speech Therapists/ Pathologists	Ministry of Health	Ministry of Health	Ministry of Health
	Speech Correction and Remediation		School Board	School Board