ACS 04-09160 (Rev 01/00)
(See Reverse Side)

School Health Services, DHS
Arlington County

AUTHORIZATION FOR MEDICATION
RELEASE AND INDEMNIFICATION AGREEMENT

PARENT or GUARDIAN (Must complete TOP SECTION for every medication)
I hereby authorize Arlington Department of Human Services and Arlington Public Schools personnel, including unlicensed persons, to give the medication described below as directed by this authorization. I agree to release, indemnify, and hold harmless Arlington Public Schools, Arlington Department of Human Services, Arlington County, and any of its officers, staff members, or agents from any lawsuit, claim, expense, demand, or action, etc., against them arising out of or in connection with assisting this student by administration of this medication to him/her as requested by the parents, including any adverse effects to the medication. I have read the "Procedures for Administering Medication in the Schools" on the reverse side and assume the responsibilities as set forth.

Student Name: _____ DOB: _____ School: _____

Teacher Name: _____ Does student attend Extended Day: Yes _____ No _____

Parent/Guardian Printed Name: _____ Daytime Phone: _____

Parent/Guardian Signature: _____ Date: _____

To Be Completed by the Licensed Prescriber: The Arlington Department of Human Services and the School Health Bureau discourage medications be given to students in school during the School/Extended Day. Please prescribe for before or after school, if at all possible.

Name of Medication: _____ Dosage: _____ Route: _____

Time To Be Given At School: _____ AM and/or _____ PM and/or Before/After _____ Activity

Diagnosis: _____ Date To Begin: _____ Date To End: _____

If the student is taking more than one medication at school, list the sequence in which medications are to be taken and the length of interval between each medication.

_____ _____ _____

If a medication is to be given on an "as needed" basis, specify the symptoms or conditions when the medication is to be given and the time interval for repeating the dose/medication.

_____ _____ _____

_____ _____
PHYSICIAN'S NAME (PRINT OR TYPE) PHYSICIAN'S SIGNATURE

Telephone Number _____ Fax Number _____ Date _____

STUDENTS WHO CARRY INHALERS: This student is both capable and responsible to self-administering the above inhaler(s). This student may carry his/her inhaler.

_____ _____ _____
PHYSICIAN'S SIGNATURE PARENT'S SIGNATURE STUDENT'S SIGNATURE

Date _____ Date _____ Date _____

FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

_____ _____ _____
SHA Signature and Date Name of PHN Contacted by Phone & Date PHN Signature and Date

ACS 04-09160 (01/00)

PROCEDURE FOR ADMINISTERING MEDICATIONS IN THE SCHOOLS

The goal of the School Health Services in the administration of medications to your child is SAFETY – the right medicine, to the right child, in the right amount, at the right time. Your help is needed to achieve this goal!

Please arrange to give all doses of medications at home whenever possible. However, if your child needs medication at school follow these 12 steps:

1. A separate Authorization form (reverse) completed by the parent/guardian and licensed prescriber is required for each medication. This is valid for no longer than one school year.

2. Faxed copies of the Authorization forms are accepted.

3. Whenever there is a change in medication dose or time of administration a new Authorization form and new labeled medication container are required.

4. When the medication needs to be taken at home AND at school, ask the pharmacist for two (2) labeled containers – one for home and one for school.

5. If your child has special requirements for taking the medication, (e.g., with applesauce, medicine needs to be broken in half, and/or elementary students wants to carry his/her inhaler) please discuss this with the school clinic staff.

6. If medications need to be broken in half, this must be done by parent. Clinic staff are not allowed to break tablets.

7. **Medication Containers:**

   A. All prescription medications must have a pharmacy label with the following information:
      - Time to be given - specify hour or activity (12 noon, after lunch, before P.E.) NOT "give as indicated"
      - Child's name
      - Name of medication
      - Physician's name
      - Dose/amount to be given

   B. All OTC (over-the-counter) medications and physician samples. They DO NOT need a pharmacy label but parent MUST:
      - Provide Authorization form completed by Parent/Guardian and Licensed Prescriber
      - Send the medication to the clinic in the original container
      - Write your child's full name on the container

8. Medications will be given no more than 30 minutes before or after the prescribed time.

9. Middle and High School students with asthma may carry and self-administer inhaler with a completed Authorization form on file in the clinic. The student and parent/guardian must agree that:
   - The student will not share the inhaler with any other student.
   - The student will carry or keep the inhaler in a secure, concealed place.
   - The student's name must be written on the inhaler.

10. Parents/guardians are advised to hand-deliver medications with Authorization forms directly to the elementary school clinic. At your discretion, middle and high school students may deliver their medications and Authorization forms to the school clinic.

11. Field Trips or other off-site school activities (e.g. Outdoor Lab) – Please discuss arrangements for medications with the school clinic staff and teacher.

12. Unused medication should be picked-up within one (1) week of expiration date of order. After that time it will be destroyed by the PHN.

Public Health Nurse _____ School Health Clinic Aide _____

Clinic Phone _____ Clinic Phone _____