Guardian Medication/Procedure Consent Form

Participant's Full Name _____

MSCR Program_____Date of Birth_____

Name of Practitioner ordering medication/procedure _____

Phone Number of Practitioner ordering medication/procedure _____

Address of Practitioner ordering medication/procedure_____

_____

Name of medication/dosage or procedure_____

Time it is to be administered_____

How it is to be administered_____

Reason for medication/procedure_____

I hereby give my permission to the nurse or delegate(s), and/or the MSCR designee or delegate(s) to give the medication or perform the procedure to my child according to the written instructions of the Practitioner as shown on the Order for Medication Administration form. I also hereby agree to give my permission to the school nurse or the MSCR designee to contact the child's Practitioner.

I further agree to hold the Madison Metropolitan School District, and the MMSD/MSCR employee(s) who is (are) administering the medication or performing the procedure harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.

I agree to notify MSCR at the termination of this request or when any change in the above order is necessary.

_____ _____

Signature of Guardian Date

Cell Phone _____ Work Phone _____

Administering Medication in MSCR Programs

1. No prescription or non-prescription drug product will be administered by school/MSCR personnel without the Medication Consent form **and** the Order for Medication Administration form filled out and returned to the School Nurse or MSCR Director's designee.
   a. Medication Consent Form must be filled out by the guardian and addressed and returned to the School Nurse or MSCR Director's designee.
   b. An Order for Medication Administration form must be filled out by a prescribing practitioner and addressed and returned to the School Nurse or MSCR Director's designee.
   c. The School Nurse or MSCR Director's designee shall maintain an accurate medication file which includes all of these necessary forms for each student/participant receiving medication. Any changes shall be communicated to the School Nurse or MSCR Director's designee by both the prescribing practitioner and parent/legal guardian.
2. Prescription drugs to be administered in the school or at an MSCR site/program must be supplied by the participant's guardian in the original pharmacy-labeled package and have the following information printed, in a legible format, on the container:
   a. Participant's full name
   b. Name of the drug and dosage
   c. Effective date
   d. Directions
   e. Time to be given
   f. Prescribing practitioner's name.
3. Nonprescription drug products to be administered in the school or at an MSCR site/program must be supplied by the participant's guardian in the original manufacturer's package and the package shall list the ingredients and recommended dosage in a legible format.
4. Prescription and non-prescription drugs will be administered to the participant at the designated time by the School Nurse or MSCR Director's designee, or by an individual who has been authorized to do so.
5. Guardian is responsible for supplying the School Nurse or MSCR Director's designee with the prescription or non-prescription drug.
6. All prescription and non prescription drug products administered at the school will be kept in a locked cubicle, drawer, or other safe place. The School Nurse or MSCR Director's designee will count and document the quantity of medication each time it is brought to school.
7. The length of time for which the drug is to be administered, which is not to exceed the current school year, including summer school or the length of the MSCR program, shall be contained in the written instructions from the prescribing practitioner, and further written instructions must be received from the prescribing practitioner with the consent of the guardian if the drug is to be discontinued or any other change is to be made in the prescribing practitioner's original instructions.
8. An accurate and confidential system of record keeping shall be established for each participant receiving medication.
   A. Information on the administration of medication shall be kept on site. Such information shall include a list of participants who are being administered medication during program hours and the type of medication, the dose, the time to be given, and the date the medication is to be discontinued. Such information should be updated periodically as practicable.
   B. An individual record for each participant receiving medication shall be kept on site by the MSCR designee, including the type of medication, the dose, the time to be given, the duration, and an inventory of the amount of medication.
   C. Each site will maintain a medication/injury log and shall record daily any medications dispensed to a child in the following manner:
      1) Record first and last name of child, name of medication, dosage, time, date and name or initials of the person administering the medication in the bound medical log on the same day that it is administered.
      2) Staff are asked to report any unusual behavior of participants on medication.
9. In the event of a drug administration error, guardian and prescribing practitioner will be notified. A written incident Report explaining the error shall be completed by the School Nurse or MSCR Director's designee or other employee involved, if any, and such report shall be filed with the student or participant health record and sent to the coordinator of health services.
10. All District employees authorized to administer drugs in the school or at an MSCR site/program shall receive training, approved by the Department of Public Instruction, prior to administering any nonprescription or prescription drug product.
11. Nothing in this policy shall be construed to limit an employee's ability, including a nurse's ability, to respond appropriately in a health emergency situation, including but not limited to administering medication, if needed.

Order for Medication Administration

Dear _____(MSCR designee), please administer the following medication(s) to (name of participant)_____, who is in the MSCR Program _____.

Diagnosis_____

DAILY MEDICATIONS

Medicine	Route	Dose	Frequency	Duration	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state)
				From: To:	
				From: To:	
				From: To:	

PRN MEDICATIONS

Medicine	Route	Dose	Frequency	Duration	Condition under which medication should be given	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state)
				From: To:		
				From: To:		
				From: To:		

Hospital/Clinic/Office _____Phone _____

Address _____

Physician's Signature _____ Date _____

Please return this form to:_____