Seaman USD #345 School District
Health Services Department

October 4, 2018

Seaman Band Parents:

My name is Jenny Crowell and I am the Health Services Director for the Seaman School District. I will be joining the Seaman High School band students on their trip to New York City in November. Kristi Wittmaier, the freshman center nurse, will be also attending. We will be available during the trip to administer any needed medications and to help students with any health issues that may arise.

Students in grades 9-12 are allowed to carry and self-administer non-prescription medications. Any student who plans on bringing non-prescription medications on this trip must have the "Seaman High School Request and Authorization to Allow Non-Prescription Medication at School/Field Trip/Extra-Curricular Events" form filled out and signed. A copy of this form is attached.

Any student who has permission to self-administer a prescription medication at Seaman High School will also be able to do this on the trip. This includes inhalers, epi-pens, and emergency migraine medications. The "Seaman USD #345 Request and Authorization for Self-Administration of Medication at School and After School Activities" must be filled out and signed by a physician. A copy of this form is also included. Controlled substances (most ADHD medications) cannot be self-administered.

All other prescription medications will be kept with the nurses and we will administer these medications to the students as prescribed. The "Seaman USD #345 Request and Authorization to allow Medication at School" form and the "Medication Count" form must be signed and sent with the medication. All medication must be sent in the bottle with a current pharmacy label.

Please feel free to reach out to me ahead of time if you would like to discuss any specific health concerns that your child has. I would be happy to visit with you and make sure we develop a plan to help your child enjoy this trip to the fullest! Kristi and I are excited and hope the kids have a great time!

Sincerely,
Jenny Crowell, MSN, RN
785-286-7103 (Mathes Early Learning Center)
jcrowell@usd345.com

SEAMAN HIGH SCHOOL
REQUEST AND AUTHORIZATION TO ALLOW
NON-PRESCRIPTION MEDICATION
AT SCHOOL/FIELD TRIP/EXTRA-CURRICULAR EVENTS
(Including Overnight Trips)

NAME OF STUDENT ________________________________ **Grade**________

I hereby request and give permission for the above named student to self-administer (per bottle/container instructions/as age appropriate) the non-prescription medication(s) listed below. I understand this form merely reflects the request that the student named above be allowed to take medication during school or field trip/extra curricular activity, and that Seaman School District #345 acknowledges this request and agrees to comply with the request if possible. I understand that Seaman School District #345 does not, in any way, guarantee that the medication(s) will be taken by the student named above. I further hereby release Seaman School District #345, it's officers and employees, from any and all responsibility for adverse effects of the medication(s) and agree to indemnify them against any and all liability, loss or damage they or any of them may incur or suffer as a result of observing or not observing the taking of the medication(s) by the student named above. *The school nurse will accept this parent request but also reserves the right to withdraw the privilege if the student shows signs of irresponsible behavior or if there is a safety risk. The school nurse will contact the parents as soon as possible in this event.*

List **ALL NON-PRESCRIPTION *Medications** (include strength, dose and their intended purpose).

Non-Prescription Medication	Dose	Route	Intended Purpose
1.			
2.			
3.			
4.			

(*Controlled substances CANNOT be self-administered, per USD #345 Medication Policy)

________________________________ ________________
(Parent/Guardian Signature) (Date)

________________________________ ________________
(School Nurse Signature) (Date)

Date ________________

Student Name __________________________ Date of Birth __________ Grade _______

A parent/guardian of the above named student has requested that the student self-administer non-prescription (OTC) medication at school and on field trips or extracurricular events. The student has been instructed on self-administration of medication(s) as noted below.

(SCHOOL NURSE AND STUDENT TO COMPLETE)

MEDICATION	PURPOSE	DOSAGE	TIME/FREQUENCY
____________	____________	____________	______________________
____________	____________	____________	______________________
____________	____________	____________	______________________
____________	____________	____________	______________________

____ YES The student understands the reason for, and adverse effects of, the non-prescription (OTC) medication being administered and verbalizes proper dosage recommendations as noted on medication container (bottle, box, etc).

____ YES The student recognizes proper timing for medication.

____ YES The student has been instructed on **NOT SHARING medication with others**, and understands that this privilege can be withdrawn if the student displays irresponsible behavior, or a safety risk has been identified. They also understand the parent/guardian will be notified if this occurs.

____ YES The student agrees to come to the health room after administration of the medication for school nurse evaluation or assistance IF requested by school staff or if symptoms that warranted medication administration are not relieved, or adverse effects occur.

____ YES The student has an understanding of calculating when medication amount is getting low and will contact parent/guardian for refill.

The school nurse will accept the parent request, and will notify school staff on a "need to know" basis. The school nurse will contact the parent/guardian, and school administration as soon as possible in the event misuse or a safety issue has been identified with the OTC Non-Prescription Self-Administration request.

________________________________ ________________________________

(Student Signature) (School Nurse Signature)

5/17

SEAMAN USD #345 REQUEST AND AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL AND AFTER SCHOOL ACTIVITIES

(PARENT OR LEGAL GUARDIAN TO COMPLETE)

Student Name ______________________ Date of Birth ____________ Grade ________

Medical Diagnosis(es): ____

Self-Administration of: _______ Medication(s) _______ Inhaler _______ EpiPen

The above named student has been instructed on self-administration of medication(s), and I hereby give my permission for him/her to self-administer at school as prescribed, the medication(s) listed below. I hereby release Seaman USD #45 School district, it's officers and employees, from any and all responsibility for adverse side effects of the medication and agree to indemnify them, against any and all liability, loss or damage they or any of them may incur or suffer as a result of self-administration of such medication(s).

______________________________ ______________

(Parent/Guardian Signature) (Date)

(PHYSICIAN OR HEALTHCARE PROVIDER TO COMPLETE)

MEDICATION	PURPOSE	DOSAGE	TIME/FREQUENCY
__________	__________	________	____________
__________	__________	________	____________

____ YES Child understands the reason for medication being prescribed.
____ YES Child demonstrates the proper technique for administering medication.
____ YES Child recognizes prescribed timing for medication.
____ YES Child has been instructed on **NOT SHARING** medication with others.
____ YES Child agrees to come to the health room after using medication for school nurse evaluation or assistance, IF requested by school staff.
____ YES Child has an understanding of calculating when medication amount is getting low and will notify parent for refill.

The school nurse will accept the parent request and physician statement. The student will be responsible for self-administration of medication, however, the school nurse reserves the right to withdraw the privilege if the student displays signs of irresponsible behavior or a safety risk is identified. The school nurse will contact the parent(s) and physician as soon as possible in this event.

I request that the child noted above carry and self-administer the above named medication(s) during school hours and at school activities.

______________________________ ______________

(Physician/Healthcare Provider Printed Name) (Date)

______________________________ ______________

(Physician/Healthcare Provider Signature) (School Nurse Signature/Date)

SEAMAN UNIFIED SCHOOL DISTRICT #345
REQUEST AND AUTHORIZATION TO ALLOW MEDICATION AT SCHOOL

NAME OF STUDENT ____

MEDICATION ____

DOSAGE _________ **Time of Day Medication is to be taken** _________

Anticipated number of days needed at school ___________________

Purpose of Medication ____________________________________

I hereby request and give permission for the above named student to take the medication as indicated above. I understand this form merely reflects the request that the student named above be allowed to take medication at school and that Seaman School District #345 acknowledges this request and agrees to comply with the request if possible. I understand that Seaman School District #345 does not, in any way, guarantee that the medication will be taken by the student named above. I further hereby release Seaman School District #345, its officers and employees, from any and all responsibility for adverse effects of the medication and agree to indemnify them against any and all liability, loss or damage they or any of them may incur or suffer as a result of observing or not observing the taking of the medication by the student named above.
I hereby authorize Seaman School District #345 Registered Nurses to exchange information regarding this request with the prescribing physician and with the pharmacy as identified on the affixed pharmacy label if clarification is required.

______________________ ______________________________

(Date) (Parent or Legal Guardian)

______________________ ______________________________

(Date Registered Nurse Notified) (Registered Nurse Notified by)

____

(Registered Nurse Initials)

8/06

SEAMAN USD #345 HEALTH SERVICES
MEDICATION COUNT FORM

Student Name: ______________________________ Date: ____________________

I am sending ____________________ of the medication(s) ________________________
(# of pills)

today to school.

____

(Signature of parent/legal guardian)