Mt. Lab 2024

Dear 8th Grade Parents:

The health service department would appreciate your assistance to ensure that the health and medication process runs smoothly so that your child will receive the best possible care while at Mountain Lab. Here are the guidelines we adhere to:

All medications that are in the health room will be transported to Mountain Lab. You do not need to do anything else for those medications.

- Any additional medication that you will be sending must be delivered to school by **8:00 Friday morning, September 6th.**
- Only send in the number of doses needed.

You may <u>not</u> drop off or send any medications with your child at Ponderosa.

- Medications brough into the cabins will be confiscated and not accessible to be given to the student for the duration of the trip.

For the safety of all students, medications are required to stay in the health center at Mountain Lab and we must have a Permission to Administer form completed for each medication. They must come in the original container and be labeled.

- WE DO NOT HAVE ANY STOCK MEDICATIONS including over-the-counter Tylenol and Ibuprofen. You must provide the medication with each form submitted.
- Students are not allowed to carry medications except EpiPens and inhalers (with completed self-carry contracts). This includes over-the-counter medications, Tylenol, Ibuprofen, Zyrtec, etc.

From the TCA Secondary Handbook:

- *"For all medications administered to students, nurses are accountable for knowing therapeutic effects, safe dosage, contradictions, including herbs, supplements, essential oils, etc."*
- Yes, this means we cannot give B-6, iron or melatonin (even if you signed a Permission to Administer Form).
- **If your child takes a non-FDA approved medication and you would like them to have it a Mountain Lab, you are welcome to volunteer as a chaperone or you may drive up to administer non-FDA approved medications to your child**.

The same D20 Illness Guidelines apply during Mountain Lab as during school: Please do not send in Dayquil, Nyquil, fever reducers, cough/cold, anti-nausea/diarrhea medication tec. "just in case" your child might develop something. If they have a fever, vomiting, diarrhea, requiring Nyquil, etc., they will need to go home.

Respectfully,

Kristen Law, MSN, RN

Lead School Nuse

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Academy District 20

PERMISSION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

TO BE COMPLETED BY HEALTH CARE PROVIDER
(FOR PRESCRIPTION or OVER-THE-COUNTER MEDICATION)

(Complete one form per medication: prescription or over-the-counter medication.)

Name of Student: _____ **Date of Birth:** _____

Medication: _____ **Reason for medication:** _____

Dosage: _____ **Route:** _____ **Time:** _____

Please list specific dosage, such as 2 tab/tsp/puffs every 4 hours, not a range such as 1-2 tab/tsp/puffs every 4-6 hours.

If 'as needed' (PRN), indicate when dose can be repeated: _____

Special Instructions: _____

Possible Side Effects: _____

Start Date: _____ **End Date:** _____

Name of Health Care Provider (print): _____ **Date:** _____

Signature of Health Care Provider with Prescriptive Authority: _____

Office Phone Number: _____ **Fax:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that whenever possible, medication should be administered at home. I understand that it is my responsibility to furnish the medication to school in the original labeled container marked with my child's name. Any prescription changes will require an additional signed and completed 'Permission to Administer Medication' form.

I give my permission for the school staff to contact the prescribing physician regarding this medication. I understand that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Academy District 20, the undersigned parent or guardian agrees to release Academy District 20 and its personnel from any legal claim which he, she or their child may now have or may hereafter have arising out of side effects or other medical consequences of the medication. I hereby give my permission for the student named above to take the above medication at school as ordered.

Name of Parent/Guardian (print): _____
Medicaid? No_____**Yes**_____ **Medicaid #** _____
Home phone: _____ **Other phone numbers:** _____
Signature of Parent/Guardian: _____ **Date:** _____

Revised: 4-27-2015