MEDICATION PACKET FOR STUDENTS WITH DIABETES

Here is a helpful checklist…

- ☐ Schedule an appointment with your child's health care provider/endocrinologist over the summer
- ☐ Ask for an updated copy of the **DMMP**-Diabetes Medical Management Plan
- ☐ Ask the physician to complete and sign the **Diabetes Self-carry** form—if you want your child to carry his/her own testing supplies and insulin
- ☐ Parent: Read and sign the **Medication letter**
- ☐ Parent: Complete the **Medical Release** form
- ☐ Parent: Read and sign the **Medication Authorization** form
- ☐ Bring the DMMP, self-carry form, medication letter and medication authorization form to the clinic along with any testing supplies you would like to store in the clinic

Note: In accordance with OCPS policy, if a student is found with medication or unauthorized inhalers, epi-pens, supplies, etc., the items will be taken and the parent/guardian will need to come to school to pick up the items.

Dear Parent/Guardian:

Due to requirements placed on the schools by Florida Statutes Chapter 232.22 (2), the following policy regarding medications dispensed at Discovery Middle School must be enforced.

Periodically, parents/guardians and physicians request that the student take medications during school hours. Parents/guardians are encouraged to develop a schedule so that the necessity for taking medications at school will be minimized or eliminated.

All medications shall be delivered to the Health Room with the following information on the pharmacy container for prescription medications and in the factory sealed container for non-prescription medication:

a. Name and purpose of medication
b. Time the medication is to be given
c. Specific instructions on the administration of the medication
d. Physician name and phone number
e. Pharmacy name and phone number
f. Approximate duration of medication, i.e., end of school year/10 days, etc., and possible side effects are to be listed on the Medication Authorization form.

Parents/guardians **must** bring all medications in the most current labeled container. Parents/ guardians will be required to fill out a Medication Authorization form before medication can be dispensed. **Notes from home will not be accepted as authorization for dispensing medication.** This applies to all prescription as well as non-prescription medication.

If there is no medication authorization form, the medication will not be dispensed. Any medication brought to school without a Medication Authorization form will be held by the School Nurse/Health Room Assistant and the parent contacted. For safety and security reasons, medications must be transported to and from school by the parent/guardian. **Do not send medications to school with the child or siblings.**

Your cooperation in this policy is greatly appreciated. We know that you can appreciate the necessity of such a policy since it deals with the safety of our children receiving medication in our school.

Thank you,

J Aldridge

Principal, Jeff Aldridge

Parent signature

Student Name

Form ID # OCPS1100Stu

Orange County Public Schools

MEDICAL RELEASE FORM

Dear Healthcare Provider: _____ _____
Physician's name Phone Number

In order to provide quality health services for: _____,
DOB: _____, at school, it is necessary to obtain a medical history and current medical diagnosis, medications prescribed, physical limitations, nutritional needs and medical orders for care at school. Records received will be placed in the student's health records in the health room accessible to the parent/guardian (or designee), along with designated school personnel.

Please forward all documents to:

Attention: Pam Furman BSN RN

School: Discovery Middle School

Address: 601 Woodbury Rd.

Orlando, FL 32828

Phone: 407-384-1555 Ext. 5052278 Fax: 407-384-1580

RECORD RELEASE

I hereby give my permission to have any records of my child (health care plans, nursing care plans, immunization history, medical history and current medications) released to my child's school to aid school personnel in serving him/her.

I give my permission for designated school personnel to contact my child's physician regarding current/pending health issues.

Expiration Date: _____. If left blank, this Authorization expires one year from the date signed.

_____ _____
Parent/Guardian Date

_____ _____ _____
Home Phone Number Work Phone Cell Number

Teacher :_____Grade:_____

Authorization for Medications

Prescriptions and Non-Prescriptions

My permission is hereby granted to _____
School

To assist_____ DOB ____/____/_____
Last First Middle MM/DD/YYYY

NOTE: If the medication is a prescription, ask your pharmacist to prepare two containers, one for school and one for home. **THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ MAY NOT BE GIVEN AT SCHOOL.** Herbal, vitamin and aspirin (salicylic acid) products require a physician's order.

Name of prescription medication (ex. Ritalin, 20 mg.): _____

Name of prescribing physician: _____

Amount to be given/dosage (ex. 10 mg.): _____

Directions for administering (ex. by mouth): _____

Specific Time to be given at school: _____

Authorization: Beginning Date: _____ Ending Date: _____

Reason or health problem: _____

Possible reaction to medication: _____

OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN ONE WEEK MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER. OVER-THE-COUNTER MEDICATIONS NEED TO BE DOSAGE SPECIFIC FOR AGE/WEIGHT. Non-prescription medications will only be accepted in the factory sealed original container. It is hereby understood by the undersigned that school personnel are not held liable for the administration of the above medication or for its possible side effects.

Medication is to be brought in its current labeled pharmacy container. For safety and security reasons, medication must be transported to and from school by the parent/guardian. **DO NOT SEND MEDICATIONS TO SCHOOL WITH THE CHILD/SIBLINGS**. Notes from home will not be accepted as authorization for dispensing medication.

_____ _____/_____/_____
Signature of parent/guardian Date

(___)_____ (___)_____ (___)_____
Home phone Work phone Cell phone / Beeper

Remember to advise the school immediately of changes in the phone numbers, addresses, responsible emergency contact person, doctor, and hospital preference.

Diabetes Authorization for Self-carry/Administration
During School and School Sponsored Activities.

Florida Statutes 385.203, Section 1002.20, House Bill (HB) 747 specifies that students with diabetes will attend their neighborhood school, carry diabetic equipment and supplies, manage their care in the classroom and participate in school-sponsored events free from discrimination. The school must be provided with parental and physician written authorization. This authorization shall identify the diabetic supplies and equipment that the student is authorized to carry and shall describe the activities the child is capable of performing without assistance. The student will keep a copy of this authorization form with their diabetic supplies.

A school district, county health department, and public-private partner, and the employees and volunteers of those entities, shall be indemnified by the parent of a student authorized to carry diabetic supplies or equipment for any and all liability with respect to the student's use of such supplies and equipment pursuant to this paragraph.

Student_____ DOB _____ Grade_____

School _____

Medication/ Supplies: See attached Diabetes Medical Management Plan (DMMP)

Duration (dates) of Administration: From _____ to _____ (Limit: One year).
I request that my child be allowed to carry diabetes medication and supplies. I understand that my child will be responsible for proper usage and storage. I take responsibility for this permission. I also understand that prescription medication must have a current pharmacy label. All non prescription medications/supplies will be accepted in the factory sealed original container and labeled with the name of the student. I will support my child to follow the above agreement and if s/he does not, I will be contacted and we will develop a new plan.

_____ _____ _____
Parent/Guardian Date Daytime Telephone Number

I have demonstrated the correct use of the medication(s) and equipment. I agree to terms of this contract. I will keep my Diabetic supplies in an agreed location. I will not share these items with others. I will notify school authorities when I need to administer the medication.

_____ _____
Student Date

I authorize this student to carry/self-administer the above medication(s) and supplies. He/she has been trained to recognize the signs/symptoms related to diabetes and to correctly use the items prescribed by me and/or my office staff.

_____
Physician's Name/Stamp

_____ _____
Physician's Signature Date

☐ Extra medication in Clinic/Health Room ☐ Original in Clinic/Health Room ☐ Copy to Student

08/01/11

Medication Receipt/Pick-up Record

School Year_____

Student Name:_____ School: _____

	Date	Medication	Expiration Date on Prescription Label (if applicable)	Expiration Date on Medication	Amount Received	OCPS Staff Signature	Parent/Guardian Signature
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							

	Date	Medication/Dose Picked -up	Amount picked up	OCPS Staff Signature	Parent/Staff Signature
1.					
2.					
3.					
4.					

Note: Please check all medications for expiration dates: Pharmacy label (if applicable) and the expiration date on the actual medication.