Pasco County Schools
General Guidelines for Administration of Medication at School

1. Administration of medication during school hours should occur only when medication schedules cannot be adjusted to provide for administration at home.
2. Medication will be administered by personnel trained by the registered professional school nurse.
3. Medication must be brought to school by the parent/guardian in the original prescription container with the original prescription label containing the following information:
    a. Student's name.
    b. Name of medication (Only FDA approved [regulated] medications will be administered at school, i.e., no herbal medications, supplements, essential oils, etc.).
    c. Dosage prescribed (If the dosage changes a new prescription bottle or script must be provided).
    d. Time of day to be taken (e.g., 9:45 AM) or if the medication is ordered as needed, how many hours in between doses (e.g., every 2 hours).
    e. Physician's name.
    f. Special instructions.
    g. Date of prescription (current, within one year).
4. No more than a month's supply (30-day supply) of medications should be brought to school by a parent/guardian, at one time.
5. All medications, whether self-carry or maintained in the clinic must be entered into the Health – Clinic System Medication Order Form. Medications administered in the clinic will be recorded on the Medication Administration Record (MAR) / Medication Inventory Record (MIR) and in the Health – Clinic System. Any changes to the time or dosage requires a new MAR / MIR to be created and a discontinuation of the Medication Order Form and a new Medication Order Form will need to be created with the updated information.
6. Medication received must be counted by at least two trained staff (additional signature from parent preferred). The amount and date received is to be recorded in the Health – Clinic System and on the individual *Medication Inventory Record* form.
7. A *Parent/Guardian Permission* form must be completed by the parent/guardian, granting the school permission to assist in the administration of such medication and which shall explain the necessity for such medication to be provided during the school day, including any occasion when the student is away from school property on official school business. Parents may not need to complete this form if authorization is provided (signed by parent/guardian) via student's *Medical Management Plan*.

*Note: It is preferred that the parent/guardian of a student obtain the needed dose(s) of medication for field trips in a separate, appropriately labeled prescription container. If that is not possible, the entire bottle of medication must be sent with a trained person to be administered on the field trip. Under no circumstances may medication be transferred from one container to another by anyone other than a registered pharmacist (no medications are to be placed in envelopes or baggies).

8. FDA approved (regulated), over-the-counter medication will not be administered at school, unless accompanied by a physician's statement, dated within the current school year (exception: *Healthy Student Program*). Over-the-counter medications must be brought to school by a parent/guardian in the original, unopened container.
9. Students will be allowed to carry metered dose asthma inhalers, pancreatic enzyme supplements, epinephrine auto-injectors and/or diabetes supplies, medication, and equipment with a completed *Authorization to Carry and Self Administer* form from their parent/guardian and physician (F.S.1002.20 (3)(h), (i), (k) and/or (j)).
10. If a student is participating in an after-school activity and has emergency medication in the clinic, the registered professional school nurse and clinic assistant must be notified by the parent/student.
11. No prescription narcotic analgesics will be administered at school.
12. Parental and healthcare provider authorization for the administration of medications and treatments is required each school year.
13. All medications must be removed from the school premises one week after the expiration date, upon appropriate notification of medication being discontinued, or at the end of the school year. If not retrieved by a parent/guardian or designee, unused and unclaimed medication will be destroyed following proper disposal procedures. Legal Authority: section 1006.062, F.S.A.

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Pasco County Schools

Individualized Seizure Action Plan for School Year 20____ - 20____

Student's Name: _____	Student ID: _____	DOB: _____	Diagnosis: _____
School: _____		Grade: _____	Home Room: _____
Parent/Guardian #1: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian #2: _____	Home #: _____	Cell #: _____	Work #: _____
Parent/Guardian's E-mail Address: _____		Preferred Communication Method: ☐ Phone ☐ Email	
Healthcare Provider: _____		Phone: _____	Fax: _____

Medical Orders (MD, PA, or ARNP who manages student's seizure disorder- complete all sections below and sign)

Seizure History

Date of Onset: _____ Date of Last Known Seizure: _____ Seizure Type: _____

Aura (If known): _____ Can Student Identify Aura: ☐ No ☐ Yes

Does the student understand his/her diagnosis? ☐ No ☐ Yes | Is the student able to identify oncoming seizure activity? ☐ No ☐ Yes

Triggers:	☐ Electronics (Type: _____ ☐ Fire Alarm/Strobe Light ☐ Anxiety/Startling ☐ Illness ☐ Sleep Deprivation ☐ Specific Time of Day/Night: _____ ☐ Nutrional Factors: _____ ☐ Other: _____

Symptoms of Seizure

☐ Staring	☐ Loss of Bower/Bladder Control
☐ Jerking Movement of Arms and Legs	☐ Not Responding to Noise or Words for Brief Periods
☐ Stiffening of the body	☐ Appearing Confused or in a Haze
☐ Breathing difficulties	☐ Nodding Head Rhythmically (Associated with loss of awareness or consciousness)
☐ Loss of Consciousness	☐ Having sudden rapid eye movements
☐ Falling Suddenly	☐ Other: _____

Seizure Management

Emergency Medication: _____	Dose: _____	Route: _____	Administer for seizure lasting longer than _____ minutes.
Emergency Medication: _____	Dose: _____	Route: _____	Administer for seizure lasting longer than _____ minutes.
Daily Medication: _____	Dose: _____	Route: _____	Time of Day: _____

Emergency Medication will be provided by parent: ☐ No ☐ Yes

Implanted Device Type: ☐ N/A ☐ VNS | **Does the student know how to use implanted device?** ☐ No ☐ Yes

VNS instructions (quantity of swipes and frequency): _____

Call 911 for the following:

☐ If seizure continues after giving emergency medication
☐ On onset of seizure
☐ If atypical seizure activity
☐ Other: _____

Call Parent/guardian/emergency contact for the following:_____

Emergency Contact:_____

Student's Name: _____ Student's DOB: _____ Student's ID#_____

Accommodations / Special Considerations: If yes please indicate accommodation(s) or restrictions needed
Is the student allowed to participate in sports? ☐ No ☐ Yes
If yes are there any restrictions? ☐ No ☐ Yes Restrictions:
Any restrictions/Accommodations needed for the following? Classroom Setting: ☐ No ☐ Yes: _____ Recess: ☐ No ☐ Yes: _____ School Activities: ☐ No ☐ Yes: _____ Transportation: ☐ No ☐ Yes: _____ After school programming: ☐ No ☐ Yes: _____ Field Trips: ☐ No ☐ Yes: _____

The medical professional who is completing this document shoud provide in this section additional medical orders not covered on this form:

Physician's/Mid-Level Practitioner's[1] Signature: _____ Date: _____

Place Office Stamp Here

I hereby authorize the above-named physician and Pasco County School's staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above-named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protect and secure the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed, or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parents(s)/guardian.
I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant to the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.

Parent/Guardian Signature: _____ Date: _____

School Health Registered Nurse Signature: _____ Date: _____

[1] In accordance with 1006.0626, FL Stat., this form must be executed by a Physician or Physician Assistant (licensed under Chap. 458 or 459, FL Stat.), or an Advanced Practiced Registered Nurse (licensed under Section 464.012, FL Stat. and who provides epilepsy or seizure disorder care to the student).

Pasco County Schools
Annual Student Medication Administration Record (MAR)

Student Name: _____ Student #: _____ Grade: _____ DOB: _____ School: _____

Medication: _____ Dosage/time(s) to be given: _____ Exp. Date: _____

Allergies: _____ Special Instructions: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sept																															
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Mar																															
Apr																															
May																															
June																															
July																															

Codes: A = Absent N = Medication not sent by parents O = No Show

Teacher / Extension: _____

Initials and name of persons administering:

_____ _____

_____ _____

Note: This form must be saved for 7 years

Attach student photo if available

Updated: 02/2023

Medication Inventory Record

Transfer amount of medication from Previous month: __________

Student name: ______________________ Student #: ______________ Grade: _____ DOB: ____________

Medication: ______________________ Dosage: ______________ Time: ______________

Date	Time	Start Count	Plus	New Amt Rec'd	Total	Minus	Amt Given	Minus	Wasted or returned / Field Trip	Actual Total W / H	Staff Initials	Staff Initials	Parent Initials	Action Taken Code	Comments	RN
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Codes: R = RN Notified, A = Admin Notified, P = Parent Notified, D = Dropped Med, E= Expired Med, F = Field Trip, O = Other

Initials and Signature of persons counting medications
