NEWPORT NEWS PUBLIC SCHOOLS
Health Services
12465 Warwick Boulevard, Newport News, VA 23606-3041 ▪ phone: 757-591-4646 ▪ fax: 757-595-2017

INSTRUCTIONS TO OBTAIN APPROVAL FOR A STUDENT TO CARRY MEDICATIONS AND/OR SUPPLIES

(LAMP, DMMP, Asthma Action Plan, Prescribed Medications including over the counter)

These requests are exceptions to School Board policy JLCD and must be approved.

1. *Parents will submit the following forms with signatures:*
   a. ***Request for Approval for Students to Carry Prescribed Medications/Supplies.***
   b. ***Responsibilities of Student and Parent Requesting Exception to Category BSC and BESO in the Rights and Responsibilities Handbook (Category BSC: Behaviors that Present a Safety Concern and Category BESO: Behaviors that Endanger Self or Others.)***
   c. ***Release of Liability***
   d. ***Appropriate medication order form signed by the Medical Provider indicating that the student may self-carry and self-administer medication(s) and/or procedures.***

2. *The Registered Nurse (School Nurse) will review the request, determine if there are any circumstances which interfere with approval and contact the prescribing physician if indicated.*

3. *The principal will be advised of the request and determine if there are any circumstances which interfere with the approval of the request.*

4. *The Health Services supervisor will be contacted for questions about approval.*

5. *Parents of students who will self- administer medication should contact the school nurse. The school nurse will discuss safety precautions, as indicated, with the principal, parents, students, teachers and other school personnel regarding students who carry prescribed medication. Students who carry any medication should be trained in how to administer it and understand when to seek assistance. The registered nurse may require a demonstration.*

6. *The parents will sign a form assuming full responsibility and releasing the school of liability.*

7. *The school's registered nurse and principal will sign approving the request.*

8. *Approval will be effective only for the school year (including summer school) in which it is signed and must be renewed annually.*

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PARENT REQUEST FOR APPROVAL FOR STUDENT TO CARRY MEDICATIONS AND/OR SUPPLIES

***This form is to be completed by the parent*. The Medical Provider must complete the appropriate medication order form(s): LAMP, DMMP, Asthma Action Plan, Prescribed Medications including over the counter.**

Name of Student: ___________________________________ Birthdate: _________________

Home Address: ____

Name of Parent(s): ____

Medications to be carried: ____

____

Additional information: ____

I request my son/daughter to carry the above prescribed medications and/or supplies. I assume responsibility for its use at school, and transportation to and from school. I release the school from liability should reactions result from this medication. ***A Medical Provider has completed the necessary order and agrees that my child needs to carry this medication/supplies and understands how to use them.*** *I understand this request is valid for one school year only.*

Parent Signature: ____________________________________ Date: ________________

Attached and completed: (All must be reviewed by RN)
___ Parent Request for Approval (parent signature required)
___ Request for Exception to BSC and BESO (parent and student signatures required)
___ Medical release of liability (parent signature required)
___ Appropriate signed order by Medical Provider indicating student is trained and may self-carry.

Notes:
____
____

Approved for current school year:

Nurse Signature: ______________________________________ Date: ________________

Principal Signature: ___________________________________ Date: ________________

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RESPONSIBILITIES OF STUDENT AND PARENT REQUESTING EXCEPTION TO CATEGORY BSC (Over the counter medications) AND CATEGORY BESO (Prescription medications)

(Request to Carry Prescribed/Over the Counter Medications on One's Person)

I request that my student, ______________________________, carry the following medications/supplies: ____
____.

I have read Category BSC and Category BESO which state:

> ***Category BSC****: Drugs: Violating school board non-prescription medication policy and look-alike drug policy. Alcohol: Distributing alcohol to other students. Drugs: Possessing drug paraphernalia*
>
> ***Category BESO****: Drugs: Possessing controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications. Drugs: Being under the influence of controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications Drugs: Using controlled substances or using illegal drugs or synthetic hallucinogens or unauthorized prescription medications. Drugs: Distributing controlled substances or prescription medications or illegal drugs or synthetic hallucinogens or alcohol to other students.*

I understand that approval of this request does not release my student from penalty if they misuse this exception. For example: knowingly taking medication improperly, giving medication to another student, or failing to report another student who tries or is suspected of trying to gain access to the medication.

I understand the penalties for misuse of this exception will result in student discipline equal to those violations of Levels 3-5, including a short-term removal from to school to long-term suspension or expulsion.

I have read, reviewed, and explained this information to my student. We understand the rules and penalties for misuse of this exception. We acknowledge the responsibilities incurred by the granting of this exception.

Parent Signature: _________________________________ Date: _______________

Student Signature: _________________________________ Date: _______________

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MEDICATION RELEASE OF LIABILITY FORM

To be used with prescribed/over the counter medications, asthma inhalers, or Epinephrine

Student: ______________________________ School: _________________________ Grade: ________

Address: ____

Parent/Guardian: ____ Phone: #____________________
(Home)

____ Phone #_____________________
(Work)

TO AUTHORIZED SCHOOL PERSONNEL:

In case of____

I hereby request and authorize you to assist and/or give

____
(Dose and Medication)

____
(Dose and Medication)

to: ____, as prescribed by
(Student's Name)

____. I release school personnel from liability
(Medical Provider's Name)

should reactions result from this medication, whether self-administered by my child or given by school personnel. If possible, I prefer follow-up care and transportation as follows:

____

____

____ _________________________________
Parent/Guardian Signature Date

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RELEASE OF LIABILITY FORM

TO BE USED WITH DMMP

School: ____ Grade: ________________

Student: ____ Birthdate: ________________

Address: ____

Parent/Guardian: ___________________________________ Phone #: ________________

I give permission for my child to self-carry diabetes related medications and supplies and to manage their care independently. I give permission for trained school personnel to provide care in the event my child needs assistance.

I will not hold the school board or any of its employees liable for any negative outcome whether resulting from self-management by my child or from care provided by trained school personnel.

I understand that the school, after consultation with the parents, may impose reasonable limitations or restrictions upon possession and/or self-administration relative to the age and maturity of the student or other relevant considerations.

I understand that the school may withdraw permission to possess and self-administer at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering medications and/or managing their own diabetes related care.

Parent Signature: _________________________________ Date: _______________