MEDICATION POLICY

Introduced:	December 2015
Review 1:	December 2021
Review 2:	December 2023
Review 3:	December 2025
Next Review:	December 2027

1. Purpose:

- To aid the body to overcome an illness.
- To relieve the symptoms of illness.
- To promote health and prevent disease.

2. Policy statement:

It is the policy of DIS that medication administration and handling is an entire responsibility of school nurse with parents' consent.

3. Scope:

All individuals and steps associated with medication procedure.

4. Target Audience:

All staffs and students of DIS.

5. Responsibility:

- Respective Class Teacher
- Student
- Parent
- School Nurse.

6. PROCEDURE:

- All prescription medication shall be stored in their original pharmacy or manufacturer labelled container, and in such manner as to render them safe and effective.
- A parent, guardian- designated responsible adult will deliver the prescription medication to the School nurse.
- The student shall take the medication under the supervision of the school nurse.
- No medication will be administered in school or during school activities or whilst on residential trips without the prior consent from a parent or guardian.
- All Prescribed medications must be administer by a written medication consent Form from the parents (appendix 1).
- The completed form needs to be submitted to the school nurse directly prior to the start of the school day with the medication.
- Only medications prescribed by a HAAD licensed physician, handed into the school clinic in the original container and accompanied with a copy of the doctor's prescription or prescription label will be accepted.
- Emergency medication will be administered to students in compliance with the Health Authority Abu Dhabi (HAAD) guidelines. HAAD requires all schools to have parental consent (appendix 2) for the school nurse to administer emergency medications in an emergency, as needed at the school.

Appendix 1

CONSENT FOR ADMINISTRATION OF PRESCRIBED MEDICATION

Student Name First……. Middle……. Last……
Date of Birth (Day/Month/Year) ……
Health condition for which the medication is prescribed……
Name of medication: ……
Dose: This medication should be continued until…….
Route for administering the medication:
By mouth Inhalation other: (Please specify).....
Injection Topical

What time / does medication need to be given at school? ……AM ……PM
Any precautions that school personnel need to know? ……
Any contraindications that school personnel need to know?
What are possible reactions/side effects?
What should be done in the event of reaction/side effect?

Tick the appropriate box below:

○ I authorize this student to self- administer the above medication.
○ The above medication can only be administered by a HAAD Licensed School Nurse.

I understand it is my responsibility to send the medication to school in the original pharmacy container labeled with my child's name, treating physician's instructions/care plan and any other documentation to assist in the safe administration of the specified medications.

Parent/Guardian-Full name:---------- Parent/Guardian signature: ----------

Date……

Appendix 2

PARENTAL CONSENT TO ADMINISTER EMERGENCY MEDICATION

I consent that my child:

Name _____ Date of Birth_____

Address _____

Phone No _____ School _____Class _____

Be given the appropriate medication in the following cases
1. Administration of Salbutamol Inhaler to control asthmatic symptoms
2. Administration or Oral Glucose for hypoglycemia
3. Administration of Paracetamol to control mild to moderate pain and fever
4. Administration (topical) of Antihistamine Cream for allergic reaction

Any precautions that school personnel need to know? ……
Any contraindications that school personnel need to know? ……
What are possible reactions/side effects? ……
What should be done in the event of reaction/side effect? ……

Tick the box below:

○ YES – The above medication can be administered by a HAAD Licensed School Nurse/Physician in accordance with this standard and the relevant policies.
○ NO – The above medication cannot be administered by a HAAD Licensed School Nurse/Physician.

Parent/Guardian-Full name: ……
Parent/Guardian signature: ……
Date ……

7. Cross Reference

1.1 Joint Commission International. PCI: Joint Commission International Accreditation for Hospitals. Third Edition USA. Joint Commission Resource.

Amendments:

Review 1	No Changes
Review 2	No Changes
Review 3	Consent forms have been added in the policy

Approved By	Signature
Mr. Paramjit Ahluwalia Principal	