

ORRVILLE MIDDLE SCHOOL

801 MINERAL SPRINGS
ORRVILLE, OH 44667
www.orrville.k12.oh.us

Dave Sovacool, Principal
Jamie Cicconetti, Assistant Principal

Phone #: 330 682-1791
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Attention Parents:

As we approach Outdoor Education, many of our students have medical needs (especially exercised induced asthma) that require medication. This fieldtrip requires a lot of walking with very little down time. We also have students that may normally take medication at home in the morning; but will need to bring them on the overnight trip.

The Orrville city school must follow the State of Ohio (O.R.C. 3313.713) medication policy. If your child needs **any type of medication (prescription, over-the-counter, herbal)** during the fieldtrip, please follow these steps:

1. The attached medication form must be filled out, signed by the parent & the child's physician. To help make the policy easier, if a parent signs the forms & returns it to the school; the school will be able to fax it to the physician office before **May 15th**. If your student's physician is affiliated with Dunlap Family Physicians you will have to take the form to the office to have it completed as they do not send medical faxes to the school.
2. Medication must be labeled correctly, in its own prescription bottle or original container. Your pharmacy is able give you a free extra bottle with a label on it for school use (if needed).
3. Medication **MUST BE** brought into the school by a parent no later than **MAY 19th**.
4. Please supply the school with **ONLY** the correct amount of medication needed on the trip. Any extra medication (except inhaler & epipen) must be picked up by the parent. Medication cannot be given back to a student to bring home.
5. By state law, if your child needs an inhaler or epipen, they will be responsible for carrying the medication with them at all times. The medication form must be filled out and state that the student knows how to use the medication.

Please contact the school nurse if you have questions or concerns.

Sincerely,

Megan K.W. Steiner, RN, BSN
Orrville Middle & High School
Phone: 330-682-1791
Fax: 330-682-2743



"Home of the Red Riders"

WAYNE COUNTY SCHOOLS
MEDICATION ADMINISTRATION
BY SCHOOL EMPLOYEES
(O.R.C. 3313.713)

[Note: ALL blanks must be filled in]

Student Name

Student's School or class

Name & Strength of the medication

Dosage & Route & Time to be administered

Reason for medication

Date administration is to start & end

Asthma Action Plan

Mild shortness of breath, coughing and wheezing:

1st dose: 2 puffs of Albuterol inhaler or 1 ampule nebulized as directed. Observe for 20 minutes and return to class if symptoms have improved.

2nd dose: If symptoms are still present after 20 minutes, repeat quick relief medication as ordered and observe for 20 minutes. Return to class if symptoms have improved.

3rd dose: If symptoms are still present after waiting 20 minutes after 2nd dose, repeat quick relief medication as ordered and call parent & physician's office.

Adverse reactions to report to the physician & special instructions for Administration of medication

For asthma, use asthma action plan as stated: YES NO

If applicable: This student received instruction in the use of the above inhaler by my trained staff or me. It is my recommendation that this student carry their inhaler on their person at all times. Yes No

If applicable: This student received instruction in the use of the above EpiPen by my trained staff or me. It is my recommendation that this student carry their EpiPen on their person at all times. Yes No

Name of Physician

Phone

Date

Signature of Physician

I hereby request and give permission to the school nurse, the principal, or the principal's designee, to administer the prescribed medication listed above to my child as instructed by the physician or authorized healthcare provider with prescriptive authority. My child has taken this medication under my supervision and has had no negative side effects. If applicable, my child may carry his/her inhaler or EpiPen as prescribed by physician on his/her person during school or school related activities as stated above. My child and I are aware of the protocols and safety issues at school.

All medication must be brought to the school in the original container as dispensed by the authorized healthcare provider, physician or pharmacist, clearly labeled. Ask the pharmacist to give you 2 containers if necessary. Send only the amount of medication that will be administered during school hours or school sponsored activities. Medications will be kept in the school clinic/office or other secure storage area.

If any revisions to the above plan or prescriber's statement occur, a written revised prescriber's statement must be submitted to the school nurse, the principal or the principal's designee. It is understood that it is the student's responsibility to seek the medication at the proper location and time unless s/he is physically or mentally unable to do so.

Signature of Parent/Guardian

Phone (Home/Work/Cell)

Date

Date received at school: _____ Initials _____