Dear Boston Prep Parent/Guardian,

Time to start planning for the 2023-2024 school year!
The following information is VERY IMPORTANT AND REQUIRED!

Please COMPLETE ALL OF THE FORMS provided in this packet and return by the START OF THE SCHOOL YEAR.

- 'Over The Counter' Medication Administration Permission: The school physician allows the school nurse to administer the Over the Counter (OTC) medications listed on the next page WITH a parent/guardian's signed consent. Any other medications require a physician's order. *Parents are responsible for obtaining physician's signature for all other medications*

- Make sure that your student has had a physical in the last 12 months and the school nurse has a copy at the start of the school year.

General safety tips

- Encourage your student to wear sunscreen (at least SPF15). Everyone, regardless of race and ethnicity, is at risk for skin cancer with sun exposure, even on a cloudy day

- Stay hydrated by drinking A LOT of water (juice and soda do not count!).

- If your student has food allergies and/or asthma, remind them to bring their epipen or inhaler everywhere they go

Please feel free to contact us *by phone* at *(617) 910-5364 or (617) 910-5310* or *email* at nurses@bostonprep.org with any questions or concerns that you may have.

Sincerely,

Malorie Golafaie, RN
School Nurse Lead

Ally Fenoglietto, RN
School Nurse

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Medication Authorization Form

Under Massachusetts General Laws (MGL) Chapter 112, Section 80B, a licensed nurse must have a medication order from a physician, dentist, nurse practitioner, or physician's assistant in order to administer any **prescription medication.**

'Over The Counter' Medication Administration Permission:

At Boston Prep, the school physician allows the school nurse to administer the Over the Counter (OTC) medications listed below. **Any other medications require a physician's order**.

My child has permission to take the following OTC medications (please check):

Acetaminophen (Tylenol) Yes ❑ No ❑	Allergy Relief (Benadryl) Yes ❑ No ❑
Ibuprofen (Motrin/Advil) Yes ❑ No ❑	Antacid (Tums/Rolaids) Yes ❑ No ❑

Please note: The school nurse may use cough drops; school nurse may also use first aid treatments, including topical ones, to treat allergic rashes, insect bites, toothaches, minor-wound infections and minor burns unless otherwise indicated by parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Student's Name: _____

Please bring this form into school or fax it to Boston Prep, Attn: SCHOOL NURSE at 857-702-0736

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Prescribed Medications: Please list prescription and over the counter medications your child takes. Include herbal treatments.

Medication Name	Medication Dose	Reason for Taking Medication

Note: Prescription and over-the-counter medications that your child must take at school require an MD/NP order. Please see below.

A licensed prescriber's form may be used instead of the one below, however, it **must be signed by the provider AND the parent/guardian.**

Licensed Prescriber's Written Medication Order (for EACH medication):

Student name: _____ ***Grade:*** _____
DOB: _____

Medical diagnosis/Reason for medication: _____

Medication: _____ Dose: _____

Route: _____ Frequency: _____Time to Administer at School: _____

Start date: _____

Duration of order: (all orders expire at the end of the school year): _____

Consent for Self-Administration of Medication (provided the School Nurse determines it is safe and appropriate)
_____Yes _____ No

Signature of Licensed Prescriber: _____, MD, NP, Other ____

Print Name: _____ Tel: _____ Date: _____

Parent/Guardian Consent:

Parent/Guardian Signature: _____

Print Name: _____ Tel: _____ Date: _____

Emergency Contact: _____ Tel: _____

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Policy
Parents/guardians have the primary responsibility for the administration of medication to their children. The administration of medication to students during the regular school hours and during school related activities is discouraged unless necessary for the critical health and well-being of the student.

Protocol for Implementation

1. **Medication Authorization Form** – School personnel shall not administer to any student (unless designated/trained by school nurse), nor shall any student possess or consume *any prescription or non-prescription medication* except after filing complete medication authorization information. The school nurse reviews the written authorization and consults with the parent/guardian or physician for additional information as necessary. Authorization and any subsequent changes include:
    a. Physician's written permission
    b. Student's name, medication name, dosage, and date of order
    c. Administration instructions (route, time or intervals, duration of prescription)
    d. Reason/intended effects and possible side effects
    e. Parent/guardian written permission
2. **Appropriate Containers** – Medication and refills are to be provided in containers, which are:
    a. Prescription labeled by a pharmacy or licensed prescriber displaying Rx number, student name, medication, dosage, and directions for administration, date and refill schedule and pharmacist name.
    b. Manufacturer labeled non-prescription over-the-counter medication.
3. **Administration of Medication** will be by the school nurse, **or** designated school administrator. Parents must provide advance notice to the school nurse of field trips or other off campus activities. Other certificated school personnel may also volunteer to assist in medication administration and may be given instructions by the nurse. If no volunteer is available, the parent/guardian must make arrangements for administration. The school nurse or administration retains the discretion to deny requests for administration of medication. Prescription medications required for 10 days or less may be administered according to the directions on the original pharmacy medication label, in place of a written order. The nurse will not accept "as directed" on prescription labels.
4. **Self-Administration** – A student may self-administer medication at school and activities if so ordered by his/her medical provider. Daily documentation will be provided as below (#6) for such health office supervised self-administration. For "as needed" medications such as those taken by students with asthma or life-threatening allergies, the physician may also order that the student carry the medication on his or her person for his/her own discretionary use according to medical instructions when the student is off-campus for school related activities. However no daily documentation will be possible if this is the case. Self-administration privileges may be withdrawn if a student exhibits behavior indicating lack of personal responsibility toward self or others with regards to medication.
5. **Storage and Record Keeping –** Medication will be stored in the nurse's office. Medication requiring refrigeration will be stored in a secure area. Each dose will be recorded in the student's individual health record. In the event a dose is not administered, the reason shall be entered in the record. Parents may be notified if indicated and it shall be entered in the record. To assist in safe monitoring of side effects and/or intended effects of the treatment with medication, faculty and staff may be informed regarding the medication plan. For long-term medication, written feedback may be provided at appropriate intervals or as requested by the licensed prescriber and/or parent/guardian.
6. **Documentation, Changes, Renewals, and Other Responsibilities** – To facilitate required documentation, medical orders, changes in medical orders, and parent permissions may be faxed to the Boston Prep School Nurse. It is the responsibility of the parent/guardian to be sure that all medication orders and permissions are brought to school, refills provided when needed, and to inform the nurse of any significant changes in the student's health. Medication remaining at the end of the school year must be released to a parent/guardian or it will be discarded within one week. Every prescription order must be renewed each school year.

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STUDENT EMERGENCY & HEALTH FORM

Student's Name: _____ Birthdate: ___ / ___ / ___

Current Grade: _____

Home Address: _____

Phone Number: _____

TELEPHONE NUMBERS:
Name of Legal Guardian/Relationship: _____

Home #	Work #	Cell #	Other

Local persons to be notified in case of emergency or illness, when you are unable to be reached:

1) Name & Relationship: _____

Home #	Work #	Cell #	Other

2) Name & Relationship: _____

Home #	Work #	Cell #	Other

3) Name & Relationship: _____

Home #	Work #	Cell #	Other

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HEALTH HISTORY:

A) Allergies
- a. Allergies to Medications: _____
- b. Allergies to Food: _____
- c. Is an Epi-Pen Required? _____
- d. What is the treatment for your child's allergic reaction? _____

B) Illness/Chronic Condition (asthma, diabetes, G6PD, seizures, ADD, etc)
- a. _____
- b. _____

C) Vision
- a. Glasses? _____
- b. Contact Lenses? ____

D) Hearing
- a. Hearing Problems? ____
- b. Hearing Aids? ____

HEALTH CARE PROVIDER INFORMATION:

Name of Doctor/Health Center: _____

Phone Number: _____

Name of Health Insurance: _____

Insurance #: _____

Name of Dentist: _____

Phone Number: _____

Confidential Information I grant permission to the school nurse to share health information about my child, on a need to know basis, with his/her teachers and coaches.

Medical Release I understand that the Boston Preparatory Charter Public School has a responsibility to my son/daughter to use responsible and prudent judgment in maintaining his/her health while engaged in the school's programs. With this in mind and in my absence: In the event of an injury or illness, I hereby give my permission for my son/daughter to receive medication and/or any other appropriate treatment (including emergency surgery) by an area doctor, hospital or other appropriate medical facility.

Health Care Provider Release I grant the school nurse permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time.

Yes___ No ___

Parent/Guardian Signature: _____ **Date**: _____

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iHealth COVID-19 Antigen Rapid Test for Symptomatic Individuals
Guardian Authorization for Student

By completing and submitting this form, I confirm that I am the appropriate guardian to provide consent, and that I authorize the administration of a COVID-19 antigen rapid test on my student at Boston Prep Charter School during school hours, should school staff observe symptoms consistent with COVID-19 or isolated symptoms (e.g., isolated runny nose, isolated headache, or isolated abdominal pain without fever). I understand that authorizing a COVID-19 test for my student is optional and that I can refuse to give this authorization, in which case, my student will not be tested. I further understand that my student must stay home if feeling unwell.

Student Demographic Information

Student's First & Last Name	
Student's Address (Street, City, Zip)	
Student's Date of Birth	
Student's Race (Select all that apply)	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Unknown
Is the student of Hispanic origin?	☐ Yes ☐ No ☐ Unknown
What is the student's gender?	☐ Male ☐ Female ☐ Transgender ☐ Unknown

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Guardian Information

Guardian's First & Last Name	
Guardian's Phone Number	
Guardian's Email Address	

Consent and Data Sharing (please initial)

In the event my student shows symptoms of COVID-19, I authorize the school nurse, during school hours, to administer the iHealth COVID-19 antigen test on my student. I understand that my student's test results will be shared with the Massachusetts Department of Public Health in accordance with state law.	

Authorized Signatory (please initial)

I understand that I can change my mind and cancel this permission at any time, but that such cancellation is forward-looking only, and will not affect information I already permitted to be released. To cancel this permission for COVID-19 testing, I need to contact the School Nurses and submit request in writing at nurses@bosotnprep.org.	

Guardian Consent

Parent/Guardian Name (Print)
Parent/Guardian Signature
Date

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