Massachusetts Department of Public Health
School Health Unit Application

Applicant School District or Non-Public School: _____

Address: _____
(Street) (City/Town) (State) (Zip Code)

Current total student enrollment: _____

Please check type of Public School/Non-Public School:

Public School System (includes Regional School Districts/School Unions/Vocational/Charter/Collaborative Schools) ☐

Approved Special Education Day School ☐ Approved Special Ed Residential School (requires on-call coverage) ☐

Non-Public Day School ☐ Residential Non-Public School (requires on-call coverage) ☐

Total Full Time Equivalent (FTE) School Nurses (RN) employed in the school/school district: _____ FTE(s)

- One nurse that works half-time would be reported as 0.5 FTE
- Do not include LPNs or clerical staff
- Less than 1.0 FTE requires on-call coverage

Please check off when delegation of medication administration by a school nurse to unlicensed school staff may occur (check ALL that apply):

☐ Off-campus: Field trips/Extra-curricular events

☐ On-campus: Before and after school programs (requires on-call coverage)

☐ During the school day

☐ Overnight/weekends (requires on-call coverage)

Please indicate, by checking all that apply below, which category(s) of unlicensed school personnel may be delegated the responsibility for medication administration in your school district/school as approved by the School Committee or Board of Trustees and in accordance with 105 CMR 210.004, (B), (1), (2):

Administrative Staff ☐ **Unlicensed Health Aides** ☐ **Teaching Staff** ☐ **Clerical Staff** ☐

SCHOOL BUILDING/SCHOOL NURSE STAFFING PROFILE

Please provide the information requested below for each school building. Copy and attach additional pages if necessary.

Name of school building: _____

Municipality where school building is located: _____

Grade levels/ages in school building: _____ **Number** of students in the building: _____

Maximum distance between any two school buildings (if the school is composed of multiple buildings): _____

Name and Credentials of DESE-licensed school nurse(s) and other healthcare staff* employed by the school (do not include per diem or substitute nurses)	**On-site schedule** for school nurse/healthcare staff (indicate **days** and **times** staff will be physically present)	**On-call schedule**** for school nurse*** (indicate whether in person or by phone)	**On-call schedule** for MAP****	**Estimated Number** of unlicensed personnel being delegated medication administration on any given day

Name of school building: _____

Municipality where school building is located: _____

Grade levels/ages in school building: _____ **Number** of students in the building: _____

Maximum distance between any two school buildings (if the school is composed of multiple buildings): _____

Name and Credentials of DESE-licensed school nurse(s) and other healthcare staff* employed by the school (do not include per diem or substitute nurses)	**On-site schedule** for school nurse/healthcare staff (indicate **days** & **times** staff will be physically present)	**On-call schedule**** for school nurse*** (indicate whether in person or by phone)	**On-call schedule** for MAP****	**Estimated Number** of unlicensed personnel being delegated medication administration on any given day

*Please include all health clinic staff that contribute to the workflow of the health clinic. This will assist the department in assessing coverage.

**On-call coverage is required for less than 1.0 FTE in any given building, before and after school programs, overnight and weekend delegation, and all residential schools.

***LPNs cannot delegate or be on call for unlicensed staff consultation.

****MAP is a delegation option that is only available to Department of Education and Secondary Education (DESE)-approved residential special education schools with a Caring Together contract through the Department of Mental Health. Please specify all hours of the week (24/7) that are covered under MAP.

ASSURANCE CHECKLIST

1. The School Health Unit of the Massachusetts Department of Public Health (MDPH) requires the applicant school district/school, with the approval by the school committee or board of trustees where applicable, to adopt policies/procedures for medication delegation where delegation is in use. The applicant school district/school provides MDPH the assurance that adoption and use of any policies/procedures and forms by the school committee or board of trustees, are consistent with regulations 105 CMR 210.000. Draft policies can be found in the Comprehensive School Health Manual.

2. The School Nurse Manager (RN), the school physician, superintendent or administrator, and school committee chairperson or board of trustees' chairperson have collaborated in the development and adoption of the medication delegation policies/procedures.

3. The school physician, superintendent or administrator, and school committee chairperson or board of trustees' chairperson agree and acknowledge the School Nurse Manager's leadership role in implementing and managing the program to administer and delegate prescription medications to unlicensed school personnel as defined in the regulations found at 105 CMR 210.000.

4. The school district or school will maintain an accessible copy of regulations 105 CMR 201.000 "*The Administration of Prescription Medications in Public and Private Schools*" and all policies/procedures and forms for review upon request.

5. **The School Nurse Manager has attended the two mandatory courses through BU SHIELD** (Medication Administration in a School Setting: School Nursing Practice in Massachusetts and Medication Administration in Schools: What School Nurse Managers Need to Know).

6. Once registered with the MDPH Drug Control Program, the School Nurse Manager agrees to report to the MDPH School Health Unit within five working days, in writing on school district/school letterhead, any change in School Nurse Manager or reduction in School Nurse staffing.

7. Implementation of the plan to delegate prescription medications will begin upon receipt of a MCSR issued by the MDPH Drug Control Program, following approval by MDPH the School Health Services Unit.

My signature on the signature page indicates that I have read and agree to the above and all other requirements under 105 CMR 210.000 pertaining to the storage, handling, administration, and disposal of medications in schools and that the information provided in this application is accurate.

SIGNATURE PAGE

I hereby attest that as the **School Nurse Manager (RN)**, I have completed this application and understand my roles as manager and supervisor of the medication storage, handling and delegation program in the applicant school system / school. I will act as the Massachusetts Department of Public Health contact on all matters relating to the administration of medications in the school setting. I have developed and/or reviewed the policies and procedures in compliance with regulations105 CMR 210.000 in consultation with the school physician and have recommended to the School Committee/Board of Trustees adoption of the policies.

_____ _____ _____

Medication Manager (RN) *(Signature /Credentials)* Medication Manager (RN) (Please Print) Date

_____

School Name and Address of Medication Manager (RN) City State Zip Code

_____ _____ _____

Telephone Number E-mail Address RN License Number

I hereby attest that as **School Physician (MD),** I have consulted with the Medication Manager (RN) in the preparation of this application. I have reviewed the regulations, policies and procedures and have recommended to the School Committee/Board of Trustees adoption of the policies.

_____ _____ _____

School Physician (MD) *(Signature)* School Physician (MD) (Please Print) Date

I hereby attest that as **Superintendent of Schools or Administrator of the School,** I agree with the intent of the regulations and with the policies as specified in this application. I thus acknowledge the Medication Manager (RN) management role and responsibility as defined in regulations 105 CMR 210.000. I have reviewed the regulations, policies and procedures and have recommended to the School Committee/Board of Trustees adoption of the policies.

_____ _____ _____

Superintendent of Schools or Administrator of School (*Signature)* Superintendent of Schools or Administrator of School (Please Print) Date

I hereby attest that as **Chair, School Committee** or **Chair, Board of Trustees**, the Committee/Board has agreed to adopt the policies and procedures governing the administration of prescription medications as defined by statute and regulation (M.G.L. 94C and 105 CMR 210.000). The School Committee/Board of Trustees has approved the categories of unlicensed personnel who may administer prescription medications and understands the Medication Manager (RN) role as manager of the medication program in the school.

_____ _____ _____

Chair, School Committee or Chair, Board of Trustees (*Signature)* Chair, School Committee or Chair, Board of Trustees (Please Print) Date

Massachusetts Department of Public Health
School Health Unit
(OPTIONAL) Medication Manager (RN) Application

Applicant School District or Non-Public School: _____

Address: _____
Street City/Town State Zip Code

In the event the current Medication Manager (RN) leaves their position, the below Registered Nurse must notify the Massachusetts Department of Public Health (MDPH) School Health Unit (SHU) to immediately become the Medication Manager (RN) for the remainder of the current registration period without lapse. Please inform MDPH SHU within seven business days from the original Medication Manager's departure. If optional back-up Medication Manager (RN) leaves their position, please inform MDPH SHU.

SIGNATURE

I hereby attest that as the **Medication Manager (RN)**, I have completed this application and understand my roles as manager and supervisor of the medication storage, handling and delegation program in the applicant school system / school. I will act as the Massachusetts Department of Public Health contact on all matters relating to the administration of medications in the school setting. I have reviewed the policies and procedures in compliance with regulations 105 CMR 210.000 in consultation with the school physician and have recommended to the School Committee/Board of Trustees adoption of the policies.

_____
Back-up Medication Manager (RN) - *Signature /Credentials (RN)*

_____ _____
Back-up School Medication Manager (RN) - *Please Print* Date

_____
School Name and Address of Medication Manager (RN) City State Zip Code

_____ _____ _____
Telephone Number E-mail Address RN License Number