

MEDICATION PLANNING GUIDE (MPG)

REQUIRED for participation in marching band

Student Last Name: _____

First Name: _____

Event/Effective Dates: _____

Parents/Guardians are encouraged to administer medication to students before and after band events whenever possible. For on-campus events during school hours, students in need of medication will be directed to MCS Health Services personnel. For band camp, extended day trips, and overnight trips, medication will be dispensed to students by Band Staff, the Medical Secretary, or a designated board-approved chaperone in accordance with MCS guidelines. For all other on-campus events outside of school hours, students in need of medication will be directed to contact a parent/guardian and make arrangements for a parent/guardian to dispense medication in person.

- A [Dispensing Medications at School](#) – MCS-202 (DMS) form is required for each OTC (over-the-counter) or Rx (prescription) medication to be dispensed. Only the MCS-202 will be accepted for the purpose of DMS.
- Required medical documents will be accessed only as needed when a student presents with a medical concern. Any student with a chronic life-threatening condition should submit a [Student with Identifiable Health Problem](#) – MCS 217 (SWIHP) form to make an emergency action plan available in advance. Only the MCS-217 will be accepted for the purpose of a SWIHP.
- As medical needs change, the parent is responsible for providing updated forms to the Band Director & the Medical Secretary.
- Parents should retain a copy/snapshot of this and all other submitted medical forms. Download forms from [Charms](#).

1. Initial all blanks that apply.

- _____ I do **NOT** expect my student to need OTC (over-the-counter) or Rx (prescription) medication at MB events. I do not plan to submit a DMS or SWIHP.
- _____ I expect my student to need OTC (over-the-counter) medication. I will submit DMS form(s) as soon as possible.
- _____ I expect my student to need Rx (prescription) medication. I will submit DMS form(s) as soon as possible.
- _____ This student has a chronic condition that may require emergency attention. I will submit a SWIHP form with an action plan as soon as possible.

2. Summarize the expected distribution schedule for medications.

- Write ONE medication name per line (Do not write dosage/administration notes on this form)
- If the medication is to be **distributed on a schedule** circle “**Breakfast**”, “**Lunch**”, “**Dinner**”, or “**Bedtime**” to indicate **each time** the medication is to be dispensed
- If the medication is to be distributed at the request of the student, circle “**As_needed**”

Medication name (only 1 per line)	Distribution times (circle ALL that apply)					For Med Sec use only
1.	Breakfast	Lunch	Dinner	Bedtime	As_needed	D Ph Pa N C M
2.	Breakfast	Lunch	Dinner	Bedtime	As_needed	D Ph Pa N C M
3.	Breakfast	Lunch	Dinner	Bedtime	As_needed	D Ph Pa N C M
4.	Breakfast	Lunch	Dinner	Bedtime	As_needed	D Ph Pa N C M
5.	Breakfast	Lunch	Dinner	Bedtime	As_needed	D Ph Pa N C M
6.	Breakfast	Lunch	Dinner	Bedtime	As_needed	D Ph Pa N C M

- For each DMS submitted, the following should be verified:
 - DMS medication name is spelled correctly and matches the name listed above
 - DMS dispensing instructions are legible, complete, and agree with the distribution schedule described above
 - DMS is signed by both a **physician** and **parent/guardian**
- Medications must be provided in a clear Ziploc bag at a Medication Drop-off event
 - At drop off, the parent is responsible for applying a label and reviewing instructions with the board-approved designee
 - Rx medications must be supplied **in the original container as directed on the DMS**
 - OTC medication must be supplied in original packaging with the manufacturers recommended instructions and warnings
 - Packaging should be kept to a minimum. **Do not provide more than a 7-day supply.**
- The student is responsible for reporting on time for all medications
- Medications not picked up at the end of the season may be disposed of at the discretion of the Medical Secretary

3. Date. Print & sign. Include a phone number.

 (Date) (Print name of Parent/Guardian) (Signature of Parent/Guardian) Phone

D-DMS received Ph-Physician Sig Pa-Parent Sig N-Name match C-Carry M-Med received