Parent Request and Physician's Order Form for Medication

Student Name: **DOB:** **School Year:**

	Diagnosis	Name	Dosage	Route	Time(s) to Give
Daily Meds	☐ ADD/ADHD ☐ Diabetes ☐ Other:				
Emergency Medications	Allergen(s): (food and/or environmental)	☐ Epi-Pen ☐ Auvi-Q	☐ 0.15mg ☐ 0.3mg	Intramuscular (IM)	☐ Upon Exposure ☐ Severe Reaction ☐ If provided, repeat dose after _______ minutes for continued symptoms.
		☐ Diphenhydramine (Benadryl)	☐ 12.5mg ☐ 25mg ☐ 50mg	By Mouth (PO)	☐ Upon Exposure ☐ Mild symptoms
Emergency Medications	Seizures	☐ Diastat Gel	☐ 5 mg ☐ 7.5 mg ☐ 10 mg	Rectal	☐ At onset of seizure ☐ After 5 minutes of seizing ☐ After 10 minutes of seizing
	Diabetes	☐ Glucagon	☐ 0.5 mg ☐ 1 mg	Intramuscular (IM)	☐ If student becomes unconscious
Asthma	Exercise Induced Asthma	☐	☐ 2 puffs	☐ Inhaler, with spacer if provided	Before exercise, as needed, to prevent symptoms
	Yellow Zone Asthma	☐	**Please check one:** ☐ 2 puffs ☐ 4 puffs ☐ 1 vial (ampule)	☐ Inhaler, with spacer if provided ☐ Nebulizer	☐ Every 4 hours as needed to relieve symptoms ☐ ________________________________
	Red Zone Asthma	☐	**Call 911** ☐ 4 puffs ☐ 1 vial (ampule)	☐ Inhaler, with spacer if provided ☐ Nebulizer	**For Emergency Symptoms**
As Needed PRN Meds					

Physician Name: ____ **Telephone:** ____ **MD Stamp Below**

Physician Signature: ____ **Date:** ____

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To be completed by parent:

I understand that:

- Non-medical personnel may conduct the medication administration in the absence of the school nurse.
- It is my responsibility to have an adult transport any medication(s) to school.
- If medication is not available at the school, 911 will be called for emergencies.
- If my child participates in before/after-school activities/sports, I will assume responsibility for contacting the coach/advisor/athletic director of my child's medical condition. I will provide extra emergency medication that may be needed during the activity. I may contact the school nurse if assistance is needed in instructing the advisor in a medical procedure or if a copy of the information needs to be shared with them.

I request that:

- My child be administered the medication as indicated in the physician's order.
- If an emergency injection is ordered, I give permission for the school nurse to instruct designated staff in the administration technique.

I authorize:

- The release and exchange of medical information between my child's physician and the school nurse/administrators that is necessary in carrying out services for my child.

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed healthcare provider.

I hereby release Endeavor Charter School and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Parent/Guardian Signature: ____________________ **Date:**____________ **Phone Number:** ____________________

Student Self- Carry and Self- Administration of Emergency Medication

To be completed by the Physician:

The student must have the medication(s) listed on the reverse side during the school day or at school sponsored events in order to function at school. **Adult supervision is not needed.** The student has been instructed in the treatment plan, self-administration for the listed medication(s) and has demonstrated the skill level to self-administer medications for:

☐ Asthma ☐ Allergy ☐ Insulin ☐ Other: ____________________

For Epi-Pen/Auvi-Q Only:

In the event the student is experiencing respiratory difficulty and is unable to administer the auto injector, a trained member of our school staff will administer the Epinephrine and call 911.

Printed Physician Name: ____________________

Physician's Signature: ____________________ **Date:** ____________

To be completed by student at school:

☐ I have demonstrated the use of medication to the school nurse.
☐ I plan to keep my medication and equipment with me at school.
☐ I will only use my medication as prescribed by my doctor.
☐ I will not allow any other person to use my medication.
☐ I will notify the school nurse if I am having more difficulty than usual with my condition.

Student Signature: ____________________ **Date:** ____________

To be completed by Parent:

- I request and give permission for my child to carry and give the medication listed on the reverse side during the school day, at school sponsored activities or while in transit to or from school. **Adult supervision is not needed.**

I understand that:

- I shall provide the school back-up medication (in addition to what the student will carry) that shall be kept at school.
- My child will be required to demonstrate the skill level necessary to use the self-administered medication to school staff trained by the school nurse.
- My child will be subject to disciplinary action if the medication is used in any other manner than prescribed.

For Epi-Pen/Auvi-Q Only:

In the even that my child is experiencing respiratory difficulty and is unable to administer the auto injector as ordered by the physician, a trained school staff member may administer the auto injector and call 911.

I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her physician.

Parent Signature: ____________________ **Date:** ____________

To be completed by School Nurse/Administrator:

I have observed the student indicated above verbalize and demonstrate the skill level necessary to use the medication prescribed by the above physician.

Staff Signature: ____________________ **Date:** ____________