

DICKENSON COUNTY PUBLIC SCHOOLS

AUTHORIZATION FOR MEDICATION: Prescription or Over-the-Counter Medication

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____
School: _____ **Phone #:** _____ **Fax#:** _____

Allergies: _____
Diagnosis: _____

MEDICATION	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIMES	SPECIAL INSTRUCTIONS/SIDE EFFECTS

List any emergency precautions / health emergencies that should be anticipated for this student; (e.g. allergy triggers, diabetic reactions, etc.): _____

The medication listed above can be self-administered and self-carried by the student safely YES NO

Physician's Name (Printed)

Physician's Signature

Physician's Telephone & Fax Numbers

Physician's Office Address

Date Completed

 This information will be obtained by School Board District Personnel

PARENTAL PERMISSION FOR MEDICATION
 (TO BE COMPLETED BY THE STUDENT'S PARENT / GUARDIAN)

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____

I grant the school nurse/trained school personnel/principal or his/her designee the permission to assist or perform the administration of each medication to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her physician to self-administer their medication(s), I grant permission for my child to self-administer their medication at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their medication, I give permission for the school nurse/trained school personnel/ principal/designee to perform the administration of the prescribed medication.

NOTE:

- **Medications must be supplied in the original container.** Ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.
- School personnel may administer only medications authorized by a physician.
- It is your responsibility to notify the school when there is a change in medication regimen.

 Parent / Guardian Name (Printed)

 Signature of Parent / Guardian

 Date Signed

 Home Phone Number

 Work/Cell Phone Number (Include Ext. if any)

DICKENSON COUNTY PUBLIC SCHOOLS

AUTHORIZATION FOR TREATMENT

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____
School: _____ **Phone #:** _____ **Fax#:** _____

Diagnosis: _____ **Allergies:** _____

TREATMENTS DURING SCHOOL HOURS

Treatment Plan: _____

PROCEDURE	TYPE	MEDS / FEEDING AMOUNT	FREQUENCY SPECIFIC TIMES	RATE / FLOW
Catheterization				
Feedings	<input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube <input type="checkbox"/> NG-Tube <input type="checkbox"/> Special _____			
Suctioning	<input type="checkbox"/> Oropharynx			
	<input type="checkbox"/> Tracheostomy <input type="checkbox"/> Deep <input type="checkbox"/> Surface			
Tracheostomy	<input type="checkbox"/> Tube Replacement			
	<input type="checkbox"/> Care (Cleaning)			
CPT				
Oxygen /Misting				
Ventilator				
Nebulizer Tx				
Pulse Oximeter				

Are any of the above procedures required for emergency care? YES NO, IF "YES", specify:

List any procedures the student has been trained to perform _____

List any limitations / precautionary measures that should be considered; e.g. physical education, outdoor activities, transporting, lifting, moving, special devices / equipment: _____

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, diabetic reactions, etc.): _____

There are no extraordinary emergency medical services available at school. Since only CPR and first aid are available until 911 arrive, is this adequate for student survival? YES NO, IF "NO", specify:

Physician's Name (Printed)

Physician's Signature

Physician's Telephone & Fax Numbers

Physician's Telephone & Fax Numbers

Physician's Office Address

Date Completed

This information will be obtained by School Board District Personnel

PARENTAL PERMISSION FOR TREATMENT
 (TO BE COMPLETED BY THE STUDENT'S PARENT / GUARDIAN)

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____

I grant the school nurse/trained school personnel/ principal or his / her designee the permission to assist or perform the administration of each treatment/procedure to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her physician to self-administer their medication(s), I grant permission for my child to self-administer their treatment at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their treatment, I give permission for the school nurse/trained school personnel/ principal/designee to perform the administration of the prescribed treatment. **NOTE: school personnel may administer only treatments authorized by a physician. It is your responsibility to notify the school when there is a change in treatment regimen.**

 Parent / Guardian Name (Printed)

 Signature of Parent / Guardian

 Date Signed

 Home Phone Number

 Work/Cell Phone Number (Include Ext. if any)