

## HEALTH RELATED SERVICES

Dear Parent/Guardian,

To ensure quality health care for your child, during the school year, please complete the attached Health History Form and Release of Information Form for your child. Please be sure to include up to date contact information and emergency phone numbers on all health forms. If contact information or emergency numbers change throughout the school year, please be sure to call the school nurse directly.

If you indicate on the Health History Form that your child needs or may need medication during school hours, please have the following form completed (in addition to the Health History Form and Release of Information Form).

- **Medication Request Form:**

This form is to be completed **by both** the licensed health care prescriber (for example: Doctor, Nurse Practitioner, Dentist, Physician Assistant) **and** the parent/guardian. Authorization for your child to be self-directed or self administer/carry is included on this form. The health care prescriber and the parent/guardian must consent for the child to be self-directed or self-administer/carry and the school nurse will assess the child and make the final determination.

Please contact me at the health office if you have any questions or concerns. Thank you for your cooperation. I can be reached between the hours of 8:00a.m. – 2:00p.m., either in the health clinic or by telephone 836-1191.

Sincerely,

*Sonya Thigpen*

School Nurse

*If your child will need medications during the school day, the medication must be brought in by an adult (do not send with the child) and any remaining medication must be picked-up on the last day of the school year, **by a parent or legal guardian**. Otherwise, the school nurse will dispose of the medication. In order for the school nurse to administer the medication, the medical consent and parental consent must be completed and signed. All medications must be in the original pharmacy labeled container.*

## HEALTH RELATED SERVICES

### PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITES

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

**A. To be completed by physician:**

I request that my patient, as listed above, receive the following medication:

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

DURATION OF TREATMENT: \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

**PLEASE CHECK ONE:**

\_\_\_ I deem this child to be **NON SELF-DIRECTED** and understand that administration of oral, topical, inhalant, and injectable medication must remain the responsibility of the school nurse, licensed practical nurse under the direction of the school nurse, physician or parent.

\_\_\_ I deem this child to be **SELF-DIRECTED** and understand that the school nurse, or other designated person in case of absence of the school nurse (including fieldtrips) will supervise administration of medication.

\_\_\_ I deem this child may **SELF-ADMINISTER and SELF-CARRY** their own medication with approval of the school nurse.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please note:** *The school nurse will assess the child's ability to be considered self-directed and/or able to self-administer/carry their medications. The school nurse is responsible for making the final determination of self-direction and/or the ability to self administer/carry medications.*

**B. To be Completed by a Parent/Guardian:**

I have consulted with my child's physician and agree with his/her recommendations. I request that my child receive the medications as prescribed above by our physician. The medication is to be furnished by me in the properly labeled container from the pharmacy.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

\*Medication must be in original pharmacy labeled container with specific orders and name of medication.

\*Medication and refills must be brought to school by parent/guardian or responsible adult.

Plan reviewed with parent/guardian:

\_\_\_\_\_  
Nurse's Signature

\_\_\_\_\_  
Date