Diocese of Corpus Christi

REQUEST FOR IN-SCHOOL ADMINISTRATION OF PRESCRIPTION/PRN/OVER THE COUNTER MEDICATION

Epi Pens and Inhalers require Action Plans

Student: _____Date of Birth: _____ School: _____Grade:_____

In certain, extenuating, limited situations, for students with chronic or acute medical conditions which do not necessitate exclusion from school, non-medical school personnel may administer health related treatments or medications "PRN" (as needed) as prescribed by a licensed practitioner and requested by the parent/guardian. In all cases the following are required:

1. Medical Doctor/Advanced Practice Nurse Signature
2. Parent Signature
3. School Principal's Signature
4. Diocesan School Health Administrator Signature

Standing Orders as per Medical Doctor /Advanced Practice Nurse

1. Diagnosis: _____
2. Signs and symptoms: _____
3. Duration of treatment/medication: _____
4. Related signs and symptoms of conditions which constitute a medical emergency for which EMS and parent called:

   _____
5. Medication to Administer: **Example: Ibuprofen 400 mg tablet by mouth every 8 hours X 2 max for headache**

_____

Medication Dose Route Frequency/Time/Max Dx.

Medical Doctor/Advanced Practice Nurse Signature: _____

Medical Doctor/Advanced Practice Nurse Print: _____

Medical Doctor/Advanced Practice Nurse Phone: _____ Date: _____

I understand that the treatment(s) and/or medications(s) will be administered by a person who is not medically trained. If in the event, the person to administer medication is uncomfortable with dosing; and medication is held; the principal and parents will be notified. I agree to hold the school and the Diocese of Corpus Christi, harmless for the administration of the PRN treatment /medication requested by the parent/guardian and for adverse reactions of side effects to the treatment. I agree to be responsible for maintaining and adequate supply of materials and/or medication at the school to meet the child's needs.

Parent/Guardian signature: _____ Date : _____

I acknowledge and will make arrangements for the above described treatment/medication to be administered under the above described circumstances.

Principal signature : _____ Date : _____

Approved ☐ Disapproved ☐ Expiration date ☐

School Health Administrator: _____ Date: _____

Updated: 08/09/2016

*List only ONE medication per form.