TANGIPAHOA PARISH SCHOOL SYSTEM
59656 PULESTON ROAD
AMITE, LOUISIANA 70422
PH:(985)748-7153 FAX:(985)748-8587

SCHOOL NURSE PROGRAM

MEDICATION AND TREATMENT ADMINISTRATION PLAN

TO BE COMPLETED BY PARENT:

Name: ______________________________ Birth Date: ____________ Sex: ______

Grade: _____ School: ______________________ Teacher: ___________________

Home Phone: __________________ Emergency Phone: ______________________

Physician: ____

TO BE COMPLETED BY PHYSICIAN

Wt: ______ *Ht:* ______ *BP:* _________ *Pulse:* ________ *Respirations:* __________

Allergies: ____

List any other diseases or abnormal findings: ______________________________________

____

List any procedures to be performed by the student which may require supervision: ___________

____

Specify any existing health problem(s) for which medication or treatment is being prescribed: ______

____

List medication or treatment prescribed during school hours: ____________________________

____

____

PHYSICIAN'S SIGNATURE: ____ DATE: _________

Medication and treatment will be administered by persons on the school staff who have had necessary training to be certified to give medications and treatments in the school setting.
MEDICATION OR TREATMENT WILL BE ADMINISTERED WITH AN ORDER FROM THE STUDENT'S PHYSICIAN.

SCHOOL NURSE: ____ ***DATE:***________________

I UNDERSTAND THAT AS LONG AS THE SCHOOL HAS AN ORDER TO GIVE MEDICATION OR TREATMENT, I AM RESPONSIBLE FOR PROVIDING MEDICATION OR TREATMENT SUPPLIES DOCUMENTED ABOVE.

PARENT/GUARDIAN: ____________________________________ *DATE:*________________