

REQUEST FOR ADMINISTRATION MEDICATION AT SCHOOL

School _____ Grade/ Home Room _____

Name of Student _____ DOB _____

PART 1: MEDICATION TO BE TAKEN AT SCHOOL – TO BE COMPLETED BY PHYSICIAN

The above mentioned student is under my care for (Diagnosis) _____

Name of Medication _____ Doseage and Route _____ Time _____

Administration to begin _____ Administration to end _____

Is this medication being prescribed outside the formulary guideline? _____

List all other medication this child is taking _____

Severe adverse reaction to be reported to the physician _____

Please list any medication allergies _____

Special instructions _____

Name of physician _____ Address _____

Phone _____ Emergency number _____

Physician's signature _____ Date _____

PART 11: TO BE COMPLETED BY PARENT OR GUARDIAN AND RETURNED TO SCHOOL

I request that the above medication be administered to my child according to the instructions provided. I agree to deliver the medicine to the school in the container in which it was dispersed by the prescribing physician or licensed pharmacist. I grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/ diagnosis and his/her educational and behavioral management needs. If the above information changes, I will submit a revised statement signed by the physician.

** Signature of parent/ guardian _____ Date _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

The school will supervise administration of medication in pill form. The school will assume responsibility for administering unit-dose liquid medication.

++Children who are in foster home placement by an agency that holds custody, the agency must sign.

PART 111: TO BE COMPLETED BY SCHOOL STAFF

Person(s) authorized to administer medication for this student. Principal should list names.

1) _____

2) _____

**Nurse Signature _____ Date _____

***Principal's Signature _____ Date _____

Dayton Early College Academy, Inc.
REQUEST FOR SELF-MEDICATION FOR ASTHMA INHALERS

School _____ Grade/Home Room _____

Name of Student _____ DOB _____

Address _____

Name of Medication/ Metered Dose Inhaler _____

Orders for use (# of puffs, frequency, with/without spacer) _____

Administration start date _____ Administration end date _____

Adverse reactions to report to prescribing practitioner _____

Adverse reactions to watch for in unauthorized user _____

Procedure to follow in the event the medication/ metered dose inhaler does not produce the expected relief from student's asthma attack _____

Other instructions

By signing below the physician or other health care provider and parent/ guardian state that it is their request that the child carry the ordered inhaler on their person at school and at school functions; they realize that because the student is self-administering medication, no adult may be aware that the student is experiencing difficulty, preventing adults from responding appropriately in an emergency; and that the child has been fully trained in the use of the inhaler, knows why, how and when to use it properly and will not give the inhaler to any other student.

Prescriber's name _____ Phone _____

Prescriber's signature _____ Date _____

Parent/ Guardian name _____ Phone: Work _____

Home _____
Parent/ Guardian signature _____

Other _____

Nurse's signature _____ Date _____

Principal's signature _____ Date _____

EATING AND FEEDING EVALUATION: CHILDREN WITH SPECIAL NEEDS

PART A

Student's Name _____ Age _____

Name of School _____ Grade Level _____ Classroom _____

1. Does the child have a disability? YES _____ NO _____

If Yes, describe the major life activities affected by the disability.

2. Does the child have special nutritional or feeding needs? YES _____ NO _____

If Yes, complete Part B of this form and have it signed by a licensed physician.

3. If the child is not disabled, does the child have special nutritional or feeding needs?

YES _____ NO _____ If yes, complete Part B of this form and have it signed by a recognized medical authority.

4. If the child does not require special meals, the parent can sign at the bottom and return the form to the school food service.

PART B

1. List any dietary restrictions or special diet. _____

2. List any allergies or food intolerances to avoid. _____

3. List food to be substituted. _____

4. List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All" _____

Cut up or chopped into bite size pieces: _____

Finely ground: _____

Pureed: _____

5. List any special equipment or utensils that are needed.

6. Indicate any other comments about the child's eating or feeding patterns.

Parent's Signature _____ Date: _____

Physician or Medical Authority's Signature _____ Date: _____