

Trousdale County Schools

PHYSICIANS FORM FOR MEDICATION & MEDICAL PROCEDURES

The Trousdale County Board of Education requires the following information when students need prescription or over-the-counter medication and/or procedure at school. This form must be completed & signed by the physician and parent/guardian before medication can be accepted or a procedure can be performed.

1. Student's Name _____ DOB _____

2. Address _____

3. School _____ Grade _____ Teacher _____

Parent/Guardian Signature Date Phone # Cell #

Emergency Contact (Other than Parent) Relationship Phone # Cell #

PARENT/GUARDIAN AUTHORIZATION

I request that school personnel assist _____ to self-administer the medication listed while at school and away from school during school activities. It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I hereby agree to release Trousdale County School System and its personnel from any legal claim that they now have or thereafter have arising out of the administration or failure to administer this medication. I will assume full responsibility for any side effects and complications that my child may have as a result of taking this medication. My child is competent to self-administer his/her medication with assistance. I understand that it is my responsibility to furnish this medication.

TO BE COMPLETED BY PHYSICIAN ONLY

4. Medication _____ Dosage/Time _____

5. Student competent to self-administer medication with assistance? Yes ___ No ___

6. Side Effects _____

7. Allergies _____

8. Dates to administer indicated medication at school: From _____ To _____

FOR STUDENTS WITH ASTHMA:

9. Please list asthma triggers: _____

10. Has the student been taught to administer their inhaler? ___ Yes ___ No

Will the student need assistance with their inhaler? ___ Yes ___ No

Are they competent to carry their inhaler with them? ___ Yes ___ No

*Usual School Procedure for an Asthma Attack: Allow student to use prescribed medication as prescribed. Encourage the student to remain calm and take slow, deep breaths. Monitor the student's response to the medication. If symptoms **decrease** after 15 minutes, return to class. If symptoms **increase** after 15 minutes, contact the parent. Allow student to repeat the inhaler dosage one more time per physician order. If symptoms persist or worsen, **CALL 911** and follow Emergency Action Plan. Continue to monitor student's breathing and general condition. Contact parent to inform of condition and be prepared to take appropriate action, including Rescue Breathing and CPR, if required, until EMS arrives.*

PROCEDURES:

10. Procedure _____

11. Is this student competent to perform this procedure? Yes ___ No ___

12. Time(s) to be performed at school _____

Physician's Signature Date Office Phone # Fax #