

## Permission to Administer Medication

Prescription and/or non-prescription medication that must be taken by students at school requires a written request from the parent/legal guardian together with a written set of instructions from the physician who has ordered the medication. The child's name, doctor's name, name of the medicine, dosage, route, frequency or time of administration, expected duration of medication regimen, possible side effects and special instructions, shall be clearly listed by the doctor on this form. Signatures are required from both the parent/legal guardian and physician. Medication must be in the original container and labeled with child's name, doctor's name, name of the medication, dosage, route, and frequency or time of administration. Please give initial dose of any new non-emergency medication at home; monitor for side effect, reaction.

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Student Emergency Contact #1 \_\_\_\_\_ Phone Number \_\_\_\_\_

Student Emergency Contact #2 \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of Attending Physician(s) \_\_\_\_\_

Physician Address \_\_\_\_\_

Physician Telephone \_\_\_\_\_ Fax \_\_\_\_\_

**MEDICATION INFORMATION (THIS SECTION SHOULD BE COMPLETED BY THE PRESCRIBING HEALTHCARE PROVIDER)**

1) Medication Name \_\_\_\_\_ Dose/Quantity \_\_\_\_\_ Route \_\_\_\_\_ Time of Administration \_\_\_\_\_

Reason for Medication \_\_\_\_\_

Adverse Reactions or Side Effects \_\_\_\_\_

\_\_\_\_\_ Start Date \_\_\_\_\_ End Date (Valid for one school year only)

2) Medication Name \_\_\_\_\_ Dose/Quantity \_\_\_\_\_ Route \_\_\_\_\_ Time of Administration \_\_\_\_\_

Reason for Medication \_\_\_\_\_

Adverse Reactions or Side Effects \_\_\_\_\_

\_\_\_\_\_ Start Date \_\_\_\_\_ End Date (Valid for one school year only)

Physician certifies this student requires the above medication during school hours.

Date \_\_\_\_\_ Physician Signature \_\_\_\_\_ (required for medication administration)

**PHYSICIAN:** If student requires an EpiPen or Inhaler, and an additional EpiPen or Inhaler is required for bus transportation or other activity, please provide an extra prescription to the parent.

**SELF-POSSESSION/SELF-ADMINISTRATION AUTHORIZATION**

**Students may possess/carry and/or self-administer medication only if authorized by the physician and parent/legal guardian.**

This student is capable of  self-carrying  self-administering:  Epinephrine  Inhaler

Physician Signature for student self-carry/administration of EpiPen/Inhaler \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian Signature for child to self-carry/administer EpiPen/Inhaler \_\_\_\_\_ Date \_\_\_\_\_

A student's authorization to possess and self-administer medication may be limited or revoked by the building principal after consultation with the school nurse and the student's parents/guardian if the student demonstrates an inability to responsibly possess and self-administer such medication. Please contact the building principal to develop a plan to address how to keep a record of administrations and when the student must seek assistance.

**PARENT/LEGAL GUARDIAN AUTHORIZATION**

I hereby request that my child be administered medication at school, by school personnel. I understand that the medication will be administered exactly as per directions of my above-named physician. I will notify the school of changes or discontinuance of this medication(s) by completing a new form. I consent and authorize the healthcare provider staff and school to share information as needed to clarify orders and assist with my child's healthcare needs. I agree that information contained herein shall be shared with individuals and staff that need to know.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Parent/Legal Guardian Name \_\_\_\_\_

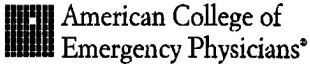
**NOTICE OF DISCONTINUATION OF MEDICATION ADMINISTRATION**

Please discontinue medication administration described above for my child \_\_\_\_\_ as of \_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Emergency Information Form for Children With Special Needs

Last name:



American Academy of Pediatrics



Date form completed  
By Whom

Revised  
Revised

Initials  
Initials

<b>Name:</b>		<b>Birth date:</b>	<b>Nickname:</b>
<b>Home Address:</b>		<b>Home/Work Phone:</b>	
<b>Parent/Guardian:</b>	<b>Emergency Contact Names &amp; Relationship:</b>		
<b>Signature/Consent*:</b>			
<b>Primary Language:</b>	<b>Phone Number(s):</b>		
<b>Physicians:</b>			
<b>Primary care physician:</b>		<b>Emergency Phone:</b>	
		<b>Fax:</b>	
<b>Current Specialty physician:</b>		<b>Emergency Phone:</b>	
<b>Specialty:</b>		<b>Fax:</b>	
<b>Current Specialty physician:</b>		<b>Emergency Phone:</b>	
<b>Specialty:</b>		<b>Fax:</b>	
<b>Anticipated Primary ED:</b>		<b>Pharmacy:</b>	
<b>Anticipated Tertiary Care Center:</b>			

<b>Diagnoses/Past Procedures/Physical Exam:</b>	
1. _____	<b>Baseline physical findings:</b>
_____	_____
2. _____	_____
_____	_____
3. _____	<b>Baseline vital signs:</b>
_____	_____
4. _____	_____
_____	_____
<b>Synopsis:</b>	<b>Baseline neurological status:</b>
_____	_____
_____	_____

\*Consent for release of this form to health care providers

Last name:

<b>Diagnoses/Past Procedures/Physical Exam continued:</b>	
<b>Medications:</b>	<b>Significant baseline ancillary findings (lab, x-ray, ECG):</b>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	<b>Prostheses/Appliances/Advanced Technology Devices:</b>
5. _____	_____
6. _____	_____

<b>Management Data:</b>	
<b>Allergies: Medications/Foods to be avoided</b>	<b>and why:</b>
1. _____	_____
2. _____	_____
3. _____	_____
<b>Procedures to be avoided</b>	<b>and why:</b>
1. _____	_____
2. _____	_____
3. _____	_____

<b>Immunizations (mm/yy)</b>											
<b>Dates</b>						<b>Dates</b>					
DPT						Hep B					
OPV						Varicella					
MMR						TB status					
HIB						Other					

Antibiotic prophylaxis: \_\_\_\_\_ Indication: \_\_\_\_\_ Medication and dose: \_\_\_\_\_

<b>Common Presenting Problems/Findings With Specific Suggested Managements</b>		
Problem	Suggested Diagnostic Studies	Treatment Considerations

<b>Comments on child, family, or other specific medical issues:</b>	
<b>Physician/Provider Signature:</b>	<b>Print Name:</b>