Birmingham PUBLIC SCHOOLS

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 College of Emergency Physicians®

American Academy of Pediatrics

Date form completed	Revised	Initials
By Whom	Revised	Initials

Name: **Birth date:** **Nickname:**

Home Address: **Home/Work Phone:**

Parent/Guardian: **Emergency Contact Names & Relationship:**

Signature/Consent*:

Primary Language: **Phone Number(s):**

Physicians:

Primary care physician: **Emergency Phone:**

Fax:

Current Specialty physician: **Emergency Phone:**

Specialty: **Fax:**

Current Specialty physician: **Emergency Phone:**

Specialty: **Fax:**

Anticipated Primary ED: **Pharmacy:**

Anticipated Tertiary Care Center:

Diagnoses/Past Procedures/Physical Exam:

1.

2.

3.

4.

Synopsis:

Baseline physical findings:

Baseline vital signs:

Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:	Significant baseline ancillary findings (lab, x-ray, ECG):
1.	
2.	
3.	
4.	Prostheses/Appliances/Advanced Technology Devices:
5.	
6.	

Management Data:

Allergies: Medications/Foods to be avoided	and why:
1.	
2.	
3.	
Procedures to be avoided	**and why:**
1.	
2.	
3.	

Immunizations (mm/yy)

Dates						Dates					
DPT						Hep B					
OPV						Varicella					
MMR						TB status					
HIB						Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: **Print Name:**