School Year
20___ - 20___

School Fax
316-_____

AUTHORIZATION FOR MEDICATION/PROCEDURE TO BE ADMINISTERED AT SCHOOL & FIELD TRIPS

Part A - Parent to Complete

Name of Student: _____ Date of Birth: _____ Grade/Teacher: _____

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school or on a field trip as indicated by my child's health care provider as described in Part B listed below.

I understand I must provide all

1. medication in its original labeled container

and/or

2. necessary supplies

I also give permission for communication between the school health professional and the medical prescriber and dispensing pharmacy related to the specific medication/treatment in question, including communication concerning:

1. the prescription or treatment itself – i.e., questions regarding dosage, method of administration, and potential drug interactions.
2. implementation of the treatment in school – i.e., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule.
3. student outcomes from the treatment – i.e., questions regarding observed side effects, possible negative reactions, observations of behavior changes in the classroom.
4. other pertinent issues related to the student's diagnosis, condition, or treatment.

_____ Parent /Legal Guardian Signature

_____ Printed Name of Parent /Legal Guardian

_____ Today's Date

_____ Home Phone

_____ Cell Phone

_____ Work Phone

_____ Parent Designee Name

_____ Parent Designee Cell Phone

_____ Parent Designee Work Phone

Part B - Health Care Provider to Complete

MEDICATION AND/OR TREATMENT ORDERS: (please specify)

Medication / Treatment	Dosage / Route	Time / Frequency	Diagnosis(es) / Indication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Special Instructions: _____

_____

_____ Signature of Physician/APRN/PA

_____ Printed Name of Physician/APRN/PA

_____ Name of the Supervising Physician **for APRN/PA**

_____ Health Care Provider Phone Number

_____ Health Care Provider FAX Number

_____ Today's Date

This student has demonstrated the skill level necessary to self-administer such medication/treatment.

☐ **Yes** _____ Signature of Physician/APRN/PA

_____ Medication(s)/Treatment(s) that can be self-administered

WICHITA PUBLIC SCHOOLS
Division of Student Support Services

DEPARTMENT OF HEALTH SERVICES

GUIDELINES FOR MEDICATION & PROCEDURES - Prescribed Special Health Care Services *(PSHCS)*

Refer to BOE Policy 5316 & 5317 *~Revised September 22, 2015*

Medication & Procedure/PSHCS requests must be renewed each school year

Procedures/PSHCS are services

- prescribed by a health care provider that require specialized training to implement.
- that are necessary to enable the student to attend school and/or programs occurring before/after school and hosted or controlled by the school. Examples of Procedures/PSHCS include injections such as insulin and emergency auto injectors.

The Licensed Registered Professional School Nurse

Regarding non-prescription and prescription medication

1. must review all medication requests prior to initiating their administration.
2. may designate and train non-nurse school employee(s) to administer medication.
    a. *If at all possible, medications should be taken prior to coming to school or after leaving school under parental supervision.*

Regarding Procedures/PSHCS

1. is responsible to review and process the request for the Procedure/PSHCS.
2. is involved in the planning and provision of the services.
    a. *The result of this planning will result in the student's own **Emergency Medical Plan** - **EMP**.*
3. may designate and train non-nurse school employee(s) to perform Procedure/PSHCS.

The Parent/Legal Guardian –

1. must provide a new **Authorization for Medication/Procedure at School** each school year.
    a. *The signature of the parent/legal guardian and completion of the **Authorization for Medication/Procedure at School** authorizes an exchange of information with the school and health care provider/agency.*

Regarding non- prescription and prescription medication

1. must notify the school immediately regarding changes. Any changes in dosage or schedule require a
    a. *new written request from the health care provider*
    b. *correctly labeled medication container*
2. will contact the nurse prior to the end of the year to discuss arrangements for transfer of medication.

Regarding Procedure/PSHCS

1. must notify the school immediately regarding changes.
    a. *Changes require a new written request from the health care provider and approval of the nurse.*
2. is responsible for providing, maintaining, servicing and replacing necessary equipment and supplies– i.e., syringes, tubing, glucose tabs, etc.
    a. *Equipment must be correctly labeled with directions for use.*
3. will contact the nurse prior to the end of the year to discuss arrangements for transfer of equipment.