DC | HEALTH

Medication and Medical Procedure Treatment Plan

Use this form to detail your student's medication and/or medical procedure plan to be administered at their school and return it to the Health Suite Personnel. The Health Suite Personnel will contact you to arrange medication/medical supply drop-off. For multiple needs, complete multiple sheets.

Part 1: Student and Parent/Caretaker Information | To be completed by student's parent/caretaker.

Student First Name:	**Student Last Name:**	**Grade:**
School Facility Name:		**Student DOB:**
Parent First Name:	**Parent Last Name:**	
Parent Email:		**Parent Phone:**

I hereby request and authorize Health Suite Personnel to administer prescribed medication/treatment as directed by the licensed health care providers to the student named in Part I. I understand that:

- I am responsible for bringing the necessary medications/medical supplies to school for the Health Suite Personnel.
- All medication/medical supplies will be stored in a secured area of the school. Health Suite Personnel will not assume any responsibility for possible loss of student medication/medical supplies.
- Within one week of the expiration of the medication/medical supplies and/or within one week of the end of the school year, I must collect what is unused or it will be destroyed.
- The School or Health Suite Personnel will not assume any responsibility for unauthorized medication/treatments that the student gives to himself/herself.
- If any changes occur in my student's health or treatment plan, I will immediately notify the school and health suite personnel annually as required by DC Official Code § 38-651.03.
- Treatment plans and medication plans must be updated annually and when there is any change in the student's health or treatment requirements.
- I hereby acknowledge that the District, and its schools, employees, and agents shall be immune from civil liability for acts of omissions under DC Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

Parent/Caretaker Signature: _____ **Date:** _____

Part 2a: Student's Medication Plan | To be completed by licensed health care provider.

Diagnosis:	**End date for school administration of this medication:**

This medication is: ❑ New; the first dose was given at home on date and time: _____ ❑ Renewal ❑ Change

Is this a standing order?
- ❑ Yes, epinephrine auto injector 0.15 mg: *refer to anaphylaxis plan*
- ❑ Yes, epinephrine auto injector 0.3 mg: *refer to anaphylaxis plan*
- ❑ Yes, albuterol sulfate 90 mcg/inh: *refer to asthma action plan*
- ❑ Yes, other: _____
- ❑ No

Name and strength of medication:	**Dose/route:**

Time and Frequency at School *(e.g. 10am and 2pm every day; as needed if standing order)*

If a reaction can be expected, please describe:

Additional instructions or emergency procedures:

Part 2b: Student's Medical Procedure Treatment Plan | To be completed by licensed health care provider.

Diagnosis:	**This procedure is:** ❑ New ❑ Renewal ❑ Change

Treatment:

When should treatment be administered at school? *(e.g. 10am and 2pm every day)*

End date for school administration of this treatment:

Additional instructions or emergency procedures:

Has the student's Universal Health Certificate form been updated to reflect new health concerns? ❑ Yes ❑ No

Licensed Health Care Provider Office Stamp

Provider Name:	
Provider Phone:	
Provider Signature:	**Date:**

OFFICE USE ONLY | Medication and/or treatment plan received by Health Suite Personnel.

Name:	**Signature:**	**Date:**

St. Coletta of Greater Washington

Seeing possibilities beyond disabilities

Authorization for Feeding Tube Procedures at School

***Healthcare provider**: Please complete and sign the following order.*

Student name: _____ Date of birth: ___/___/___

Student diagnosis: _____

Student address: _____

Student telephone number: _____

Please specify which of the following are indicated for this student while at school.

☐ Replace g-tube as needed *OR* ☐ Do not replace g-tube

Reason for procedure: _____

Precautions, possible adverse reactions: _____

☐ Tube feeding

Formula: _____

Route of administration: _____

Quantity: _____

Time: _____

Delivery (bolus, pump, etc.), given over how many minutes: _____

Flush: _____

Reason for procedure: _____

Precautions, possible adverse reactions: _____

☐ Oral intake (NPO, pureed, thickened liquids, etc.): _____

Date of authorization: ___/___/___ Order expiration date: ___/___/___

Healthcare provider name: _____

Healthcare provider telephone number: _____

Healthcare provider signature: _____ Date: ___/___/___

***Parent/guardian**: Please complete and sign the following.*

I hereby authorize the school nurse/trained school personnel to perform enteral tube feeding procedures as directed by the physician for my child (insert name here) _____. I have read and agree to comply with the District of Columbia School Health Program regulations regarding authorization for specific health assistance in school.

Parent/guardian name: _____

Parent/guardian signature: _____ Date: ___/___/___

***School nurse signature**:* _____ Date: ___/___/___

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