ANNE ARUNDEL COUNTY
SCHOOL HEALTH SERVICES PROGRAM

PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

FOR COMPLETION BY PARENT/GUARDIAN

Name of Student: _____ D.O.B: ____/____/____
(LAST) (FIRST) (MI)

Name of School: _____ Grade: _____ School Year: _____

In order for my child to receive medication in school, I agree to the following:

- All prescription and non-prescription medication will have a physician's signed order **fully** completed for each school year.
- The prescription medication will be in a container labeled by the pharmacist or physician with:
- *Name of child.* *Name of the medication.* *Dosage, route and time of administration.*
- *Name of physician.* *Prescription date and expiration date.* *Conditions for proper storage.*
- The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
- The medication will be brought to school by an adult.
- The physician will be called if a question arises about my child's medication.
- The first dose of this medication (except for epinephrine auto-injector) has been given without problems.

Having read the above conditions, I request Anne Arundel County School Health Services personnel administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

Signature of Parent/Guardian: _____ Date: _____

Relationship to student _____
Phone Number: (H)_____ (W)_____ Other_____
Address: _____

PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL
ONE MEDICATION PER FORM

Diagnosis: _____

Name of Medication: _____

Dosage: _____(mg, ml, ml/tsp, # of puffs)

Route: _____ Time of Administration at School: _____ ☐ Lunchtime

If PRN, for what symptoms? _____How Often?_____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

_____

Student medication allergies: ☐ None Known _____

Services from ☐ the beginning to the end of school year **OR**
Services should begin (Date) _____ and terminate (Date)_____ .

FOR INHALER, EPINEPHRINE AUTO-INJECTOR, AND INSULIN ONLY:

_____ It has been determined that this student is able to self-administer and carry inhalant medication or epinephrine auto-injector and has been trained in its use, including knowing when the medication is to be used.

_____ It has been determined that this student is able to self-administer insulin.

_____ This student should not self-administer inhalant medication, insulin, or epinephrine auto-injector.

Physician's Signature: _____ Date: _____
Original signature/NO stamps

Physician's Name (Printed): _____

Address: _____

Telephone Number: _____

☐ Order and MAR Reviewed _____R.N. Date_____

Revised 8/15

ANNE ARUNDEL COUNTY SCHOOL HEALTH SERVICES

Parent's Request To Perform Treatment Procedure

To Parents:

The undersigned parent(s) (or guardian) of _____ hereby request(s) personnel employed by either the Anne Arundel County Public Schools or the Anne Arundel County Health Department to see that said child receives **Jejunostomy Tube Feeding & Care** (treatment) **AS PRESCRIBED BELOW BY THE CHILD'S PHYSICIAN.** It is required by the Anne Arundel County Public Schools and Anne Arundel County Health Department as a condition to its agreement to administer any treatment that the parent must supply the school with supplies for all procedures and be present for the first time a treatment is performed. It is understood that the treatment is administered solely at the request of and accommodation to the undersigned parent(s) or guardian. In consideration of the acceptance of the request to perform this service by any personnel employed by either Anne Arundel County Public Schools or Anne Arundel County Health Department the undersigned parent(s) or guardian hereby agree(s) to release the said institutions and their personnel from any legal claim(s) which they now have or may hereafter have arising out of the performance of the treatment to the student.

I understand that this procedure will be performed using standard nursing procedures. If the procedure is uncomplicated and my child's condition is stable; the school nurse may, at her discretion, teach unlicensed personnel this procedure. School or health personnel may assist toward independence in care if indicated.

School child attends **Ruth Parker Eason School**

_____ _____

Signature of Parent or Guardian Date

****

PHYSICIAN'S SIGNED ORDER FOR TREATMENT AT SCHOOL

Name of Student _____ Date of Birth _____

Last First M.I.

Diagnosis _____

I request the following Treatment Procedure be administered during school hours:

Liquid Nutrition - _____ mls administered via jejunostomy tube at lunchtime. Water Flush - _____ mls.

Delivery Method - ☐ Pump – Set Rate at _____ mls/hr ☐ Bolus ☐ Gravity

☐ Vent jejunostomy tube PRN for complaints of abdominal discomfort and/or bloating.

☐ Replace jejunostomy tube PRN if current one becomes dislodged.

☐ Administer ___ ml water via j-tube PRN for _____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

☐ Vent prior to administration of Liquid Nutrition.

☐ If retching and/or vomiting occur, discontinue feeding and notify parent/guardian.

Services should begin _____ and terminate _____

Date Date

_____ Physician's Signature _____

Physician's Name (Printed) Address _____

Phone _____ Date _____

ANNE ARUNDEL COUNTY SCHOOL HEALTH SERVICES

Parent's Request To Perform Treatment Procedure

To Parents:

The undersigned parent(s) (or guardian) of _____ hereby request(s) personnel employed by either the Anne Arundel County Public Schools or the Anne Arundel County Health Department to see that said child receives _____ **AS PRESCRIBED** (treatment)

BELOW BY THE CHILD'S PHYSICIAN. It is required by the Anne Arundel County Public Schools and Anne Arundel County Health Department as a condition to its agreement to administer any treatment that the parent must supply the school with supplies for all procedures and be present for the first time a treatment is performed. It is understood that the treatment is administered solely at the request of and accommodation to the undersigned parent(s) or guardian. In consideration of the acceptance of the request to perform this service by any personnel employed by either Anne Arundel County Public Schools or Anne Arundel County Health Department the undersigned parent(s) or guardian hereby agree(s) to release the said institutions and their personnel from any legal claim(s) which they now have or may hereafter have arising out of the performance of the treatment to the student.

I understand that this procedure will be performed using standard nursing procedures. If the procedure is uncomplicated and my child's condition is stable; the school nurse may, at her discretion, teach unlicensed personnel this procedure. School or health personnel may assist toward independence in care if indicated.

School child attends _____

_____ _____

Signature of Parent or Guardian Date

****

PHYSICIAN'S SIGNED ORDER FOR TREATMENT AT SCHOOL

Name of Student _____ Date of Birth _____

Last First M.I.

Diagnosis _____

I request the following Treatment Procedure be administered during school hours:

_____

_____

_____

_____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

_____

_____

Services should begin _____ and terminate _____

Date Date

_____ Physician's Signature _____

Physician's Name (Printed) Address _____

Phone _____ Date _____

_____

Signature of Reviewing School Nurse

ANNE ARUNDEL COUNTY SCHOOL HEALTH SERVICES

Parent's Request To Perform Treatment Procedure

To Parents:

The undersigned parent(s) (or guardian) of _____ hereby request(s) personnel employed by either the Anne Arundel County Public Schools or the Anne Arundel County Health Department to see that said child receives **OXYGEN/PULSE OXIMETER** **AS PRESCRIBED**
(treatment)
BELOW BY THE CHILD'S PHYSICIAN. It is required by the Anne Arundel County Public Schools and Anne Arundel County Health Department as a condition to its agreement to administer any treatment that the parent must supply the school with supplies for all procedures and be present for the first time a treatment is performed. It is understood that the treatment is administered solely at the request of and accommodation to the undersigned parent(s) or guardian. In consideration of the acceptance of the request to perform this service by any personnel employed by either Anne Arundel County Public Schools or Anne Arundel County Health Department the undersigned parent(s) or guardian hereby agree(s) to release the said institutions and their personnel from any legal claim(s) which they now have or may hereafter have arising out of the performance of the treatment to the student.

I understand that this procedure will be performed using standard nursing procedures. If the procedure is uncomplicated and my child's condition is stable; the school nurse may, at her discretion, teach unlicensed personnel this procedure. School or health personnel may assist toward independence in care if indicated.

School child attends **RUTH PARKER EASON**

_____ _____
Signature of Parent or Guardian Date

****

PHYSICIAN'S SIGNED ORDER FOR TREATMENT AT SCHOOL

Name of Student _____ Date of Birth _____
Last First M.I.

Diagnosis _____

I request the following Treatment Procedure be administered during school hours:

Oxygen liters/min (%) PRN for respiratory distress &/or oxygen saturation levels < %

Utilize pulse oximeter to measure oxygen saturation levels PRN for signs & symptoms of respiratory distress

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

Services should begin _____ and terminate _____
Date Date

_____ Physician's Signature _____
Physician's Name (Printed) Address _____
Phone _____ Date _____

ANNE ARUNDEL COUNTY SCHOOL HEALTH SERVICES

Parent's Request To Perform Treatment Procedure

To Parents:

The undersigned parent(s) (or guardian) of _____ hereby request(s) personnel employed by either the Anne Arundel County Public Schools or the Anne Arundel County Health Department to see that said child receives **TRACHEOSTOMY CARE** **AS PRESCRIBED**
(treatment)
BELOW BY THE CHILD'S PHYSICIAN. It is required by the Anne Arundel County Public Schools and Anne Arundel County Health Department as a condition to its agreement to administer any treatment that the parent must supply the school with supplies for all procedures and be present for the first time a treatment is performed. It is understood that the treatment is administered solely at the request of and accommodation to the undersigned parent(s) or guardian. In consideration of the acceptance of the request to perform this service by any personnel employed by either Anne Arundel County Public Schools or Anne Arundel County Health Department the undersigned parent(s) or guardian hereby agree(s) to release the said institutions and their personnel from any legal claim(s) which they now have or may hereafter have arising out of the performance of the treatment to the student.

I understand that this procedure will be performed using standard nursing procedures. If the procedure is uncomplicated and my child's condition is stable; the school nurse may, at her discretion, teach unlicensed personnel this procedure. School or health personnel may assist toward independence in care if indicated.

School child attends **RUTH PARKER EASON**

_____ _____
Signature of Parent or Guardian Date

****

PHYSICIAN'S SIGNED ORDER FOR TREATMENT AT SCHOOL

Name of Student _____ Date of Birth _____
Last First M.I.

Diagnosis _____

I request the following Treatment Procedure be administered during school hours:

Clean or change tracheostomy inner cannulas PRN for increased secretions &/or mucous plugs
Change SHILEY # Uncuffed Tracheostomy PRN for obstruction. May use Shiley #
Tracheostomy as back up

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

_____
_____

Services should begin _____ and terminate _____
Date Date

_____ Physician's Signature _____
Physician's Name (Printed) Address _____
Phone _____ Date _____

ANNE ARUNDEL COUNTY SCHOOL HEALTH SERVICES

Parent's Request To Perform Treatment Procedure

To Parents:

The undersigned parent(s) (or guardian) of _____ hereby request(s) personnel employed by either the Anne Arundel County Public Schools or the Anne Arundel County Health Department to see that said child receives **SUCTIONING** **AS PRESCRIBED**
(treatment)
BELOW BY THE CHILD'S PHYSICIAN. It is required by the Anne Arundel County Public Schools and Anne Arundel County Health Department as a condition to its agreement to administer any treatment that the parent must supply the school with supplies for all procedures and be present for the first time a treatment is performed. It is understood that the treatment is administered solely at the request of and accommodation to the undersigned parent(s) or guardian. In consideration of the acceptance of the request to perform this service by any personnel employed by either Anne Arundel County Public Schools or Anne Arundel County Health Department the undersigned parent(s) or guardian hereby agree(s) to release the said institutions and their personnel from any legal claim(s) which they now have or may hereafter have arising out of the performance of the treatment to the student.

I understand that this procedure will be performed using standard nursing procedures. If the procedure is uncomplicated and my child's condition is stable; the school nurse may, at her discretion, teach unlicensed personnel this procedure. School or health personnel may assist toward independence in care if indicated.

School child attends **RUTH PARKER EASON**

_____ _____
Signature of Parent or Guardian Date

****

PHYSICIAN'S SIGNED ORDER FOR TREATMENT AT SCHOOL

Name of Student _____ Date of Birth _____
Last First M.I.

Diagnosis _____

I request the following Treatment Procedure be administered during school hours:

Oropharyngeal Suctioning PRN for increased secretions &/or mucous plugs

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

Services should begin _____ and terminate _____
Date Date

_____ Physician's Signature _____
Physician's Name (Printed) Address _____
Phone _____ Date _____