PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

	FOR COMPLETION BY PAR	ENT/GUARDIAN	
Name of Student: (LAST)	(EID CT)	(MI)	D.O.B://
	(FRS1)		School Year:
	medication in school, I agree to		DOINGE FORE.
 All prescription and non-prescription medication will Name of child. Name Name of physician. Pres The non-prescription medication the container in a position that The medication will be brought The physician will be called if a The first dose of this medication 	ption medication will have a physicial be in a container labeled by the phase of the medication. cription date and expiration date. In will be in the original sealed contain does not obscure the label. to school by an adult, question arises about my child's medical (except for epinephrine auto-injector)	an's signed order fully commacist or physician with Dosage, route and tin Conditions for proper ner with the label intact. dication. or) has been given without the label with the label intact.	h: ne of administration. storage. Student's name will be put on ut problems.
the medication as prescribed by treatment for the student name	ns, I request Anne Arundel Cour the physician below. I certify th d above, including the administre an:	at I have legal autho ation of medication a	rity to consent to medical t school.
Relationship to studentPhone Number: (H)	(W)	Other_	
Address:			
Diagnosis:	IAN'S SIGNED ORDER FOR M ONE MEDICATION P		
Route: Time	of Administration at School;		Lunchtime
Please list any specific precautions	personnel should be aware of or any	unusual effects that mig	ht be observed.
Student medication allergies: No	one Known		
Services from ☐ the beginning to the Services should begin (Date)	ne end of school year OR and terminate (Date)		
FOR INHALER, EPINEPHRIN	E AUTO-INJECTOR, AND INSU	LIN ONLY:	
It has been determined that injector and has been trained	t this student is able to self-administe ed in its use, including knowing when	er and carry inhalant med in the medication is to be	dication or epinephrine auto- used.
It has been determined that	t this student is able to self-administe	r insulin.	
	f-administer inhalant medication, ins		•
Physician's Signature:		Date	
	Original signature/NO stamps		
Address:			
Telephone Number:			
☐ Order and MAR Reviewed		R.N. Date	

To Parents:		
Department to see that said child receives BELOW BY THE CHILD'S PHYSICI Anna Arandal County Health Department	Arundel County Public Schools or the Anne Arundel Co Jejunostomy Tube Feeding & Care AS PRESC (treatment) IAN. It is required by the Anne Arundel County Public at as a condition to its agreement to administer any treatment.	Schools and nent that the
performed. It is understood that the treats undersigned parent(s) or guardian. In co- any personnel employed by either Anna Department the undersigned parent(s) or	lies for all procedures and be present for the first time a ment is administered solely at the request of and accommon nsideration of the acceptance of the request to perform the Arundel County Public Schools or Anne Arundel Corr guardian hereby agree(s) to release the said institution they now have or may hereafter have arising out of the performance o	is service by bunty Health ns and their
uncomplicated and my child's condition	e performed using standard nursing procedures. If the is stable; the school nurse may, at her discretion, teach personnel may assist toward independence in care if indicates the control of the personnel may assist toward independence in care if indicates the control of the control of the personnel may assist toward independence in care if indicates the control of	n umicenseu
School child attends Ruth Parker East	son School	
Ci / CDt or Coordina	Date	
Signature of Parent or Guardian		

PHYSICIAN'S SIGN	NED ORDER FOR TREATMENT AT SCHOOL Date of	
PHYSICIAN'S SIGN Name of Student	NED ORDER FOR TREATMENT AT SCHOOL Date of Birth	
PHYSICIAN'S SIGN Name of Student Last Diagnosis I request the following Treatment Procedu Liquid Nutrition - mls admin	Date of Birth First M.I. The be administered during school hours: istered via jejunostomy tube at lunchtime. Water Flush -	mls.
PHYSICIAN'S SIGN Name of Student Last Diagnosis I request the following Treatment Procedu Liquid Nutrition - mls admin Delivery Method - Pump - Set Ra	Date of Birth First M.I. The be administered during school hours: istered via jejunostomy tube at lunchtime. Water Flush - te at mls/hr Bolus Gravity	mls.
Name of Student Last Diagnosis I request the following Treatment Procedu Liquid Nutrition - mls admin Delivery Method - Pump - Set Ra Vent jejunostomy tube PRN for co	Date of Birth First M.I. The be administered during school hours: istered via jejunostomy tube at lunchtime. Water Flush the at mls/hr Bolus Gravity complaints of abdominal discomfort and/or bloating. current one becomes dislodged.	mls.
PHYSICIAN'S SIGN Name of Student Last Diagnosis I request the following Treatment Procedu Liquid Nutrition - mls admin Delivery Method - Pump - Set Ra Vent jejunostomy tube PRN for co Replace jejunostomy tube PRN if	Date of Birth First M.I. The beadministered during school hours: istered via jejunostomy tube at lunchtime. Water Flush the at mls/hr Bolus Gravity complaints of abdominal discomfort and/or bloating. Current one becomes dislodged.	
PHYSICIAN'S SIGN Name of Student Last Diagnosis I request the following Treatment Procedure Liquid Nutrition - mls admining Delivery Method - Pump - Set Rame Vent jejunostomy tube PRN for comparing Replace jejunostomy tube PRN if Administer ml water via j-tube Please list any specific precautions personal	Date of Birth First M.I. we be administered during school hours: istered via jejunostomy tube at lunchtime. Water Flush te at mls/hr Bolus Gravity complaints of abdominal discomfort and/or bloating. current one becomes dislodged. PRN for mel should be aware of or any unusual effects that might be	
PHYSICIAN'S SIGN Name of Student Last Diagnosis I request the following Treatment Procedu Liquid Nutrition - mls admin Delivery Method - Pump - Set Ra Vent jejunostomy tube PRN for co Replace jejunostomy tube PRN if Administer ml water via j-tube Please list any specific precautions person	Date of Birth First M.I. we be administered during school hours: istered via jejunostomy tube at lunchtime. Water Flush te at mls/hr Bolus Gravity complaints of abdominal discomfort and/or bloating. current one becomes dislodged. PRN for mel should be aware of or any unusual effects that might be maid Nutrition.	
Name of Student Last Diagnosis I request the following Treatment Procedu Liquid Nutrition - mls admin Delivery Method - Pump - Set Ra Vent jejunostomy tube PRN for co Replace jejunostomy tube PRN if Administer ml water via j-tube Please list any specific precautions person Vent prior to administration of Liquid Nutrition of Liquid Nutrition and/or vomiting occur,	Date of Birth First M.I. we be administered during school hours: istered via jejunostomy tube at lunchtime. Water Flush te at mls/hr Bolus Gravity complaints of abdominal discomfort and/or bloating. current one becomes dislodged. PRN for mel should be aware of or any unusual effects that might be quid Nutrition. discontinue feeding and notify parent/guardian.	
Name of Student Last Diagnosis I request the following Treatment Procedu Liquid Nutrition - mls admin Delivery Method - Pump - Set Ra Vent jejunostomy tube PRN for co Replace jejunostomy tube PRN if Administer ml water via j-tube Please list any specific precautions person Vent prior to administration of Liquid Nutrition of Liquid Nutrition and/or vomiting occur,	Date of Birth First M.I. we be administered during school hours: istered via jejunostomy tube at lunchtime. Water Flush te at mls/hr Bolus Gravity complaints of abdominal discomfort and/or bloating. current one becomes dislodged. PRN for mel should be aware of or any unusual effects that might be maid Nutrition.	
Name of Student Last Diagnosis I request the following Treatment Procedu Liquid Nutrition - mls admin Delivery Method - Pump - Set Ra Vent jejunostomy tube PRN for co Replace jejunostomy tube PRN if Administer ml water via j-tube Please list any specific precautions person Vent prior to administration of Liquid Nutrition of Liquid Nutrition and/or vomiting occur,	Date of Birth First M.I. The beadministered during school hours: istered via jejunostomy tube at lunchtime. Water Flush the at mls/hr Bolus Gravity complaints of abdominal discomfort and/or bloating. current one becomes dislodged. PRN for nel should be aware of or any unusual effects that might be quid Nutrition. discontinue feeding and notify parent/guardian. and terminate Date	observed.
Name of Student Last Diagnosis I request the following Treatment Procedu Liquid Nutrition - mls admin Delivery Method - Pump - Set Ra Vent jejunostomy tube PRN for co Replace jejunostomy tube PRN if Administer ml water via j-tube Please list any specific precautions person Vent prior to administration of Liquid Nutrition of Liquid Nutrition and/or vomiting occur,	Date of Birth First M.I. we be administered during school hours: istered via jejunostomy tube at lunchtime. Water Flush te at mls/hr Bolus Gravity complaints of abdominal discomfort and/or bloating. current one becomes dislodged. PRN for mel should be aware of or any unusual effects that might be quid Nutrition. discontinue feeding and notify parent/guardian.	observed.

Parent's Request To Perform Treatment Procedure

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o Parents:		hereby request(s)
he undersigned parent(s) (or guardian) of personnel employed by either the Anne Ar	undel County Public Schools or the Anne A	Arundel County Health AS PRESCRIBED
Anne Arundel County Health Department parent must supply the school with supply erformed. It is understood that the treat undersigned parent(s) or guardian. In county personnel employed by either Annother Department the undersigned parent(s) of personnel from any legal claim(s) which	(freatment) IAN. It is required by the Anne Arundel at as a condition to its agreement to adminities for all procedures and be present for ment is administered solely at the request ansideration of the acceptance of the request are Arundel County Public Schools or A or guardian hereby agree(s) to release the they now have or may hereafter have arising	of and accommodation to the set to perform this service by nne Arundel County Health e said institutions and their ing out of the performance of
understand that this procedure will buncomplicated and my child's condition personnel this procedure. School or healt	e performed using standard nursing product is stable; the school nurse may, at her had personnel may assist toward independent	discretion, teach unlicensed to care if indicated.
School child attends		
		Date
Signature of Parent or Guardian		
**************************************	**************************************	
Name of Student	Date Birth	
Last	First M.I.	·
The second		
Diagnosis Leguest the following Treatment Proceed	dure be administered during school hours:	
Troques		
Please list any specific precautions person	onnel should be aware of or any unusual ef	fects that might be observed.
	and terminate	
Services should beginDate	and want	Date
·	Physician's Signature	
Physician's Name (Printed)	AddressPhone	Date
F Payiewing School Nurse		Revised 08/08

Signature of Reviewing School Nurse LASHARED\FORMS\TreatmentProcedures.doc

personnel employ	parent(s) (or guardian) ed by either the Anne e that said child receiv	Arundel County 1	Public Schools or th N/PULSE OXIME (treatment)	
Anne Arundel Coparent must supp performed. It is a undersigned parent any personnel er Department the	ounty Health Departm ly the school with su understood that the tre nt(s) or guardian. In nployed by either A undersigned parent(s) ny legal claim(s) whice	nent as a condition of the consideration of the consideration of the consideration of the consideration has been guardian her	n to its agreement cedures and be pre- stered solely at the the acceptance of t unty Public Schoo eby agree(s) to re	Arundel County Public Schools and to administer any treatment that the esent for the first time a treatment is request of and accommodation to the he request to perform this service by ls or Anne Arundel County Health elease the said institutions and their ave arising out of the performance of
uncomplicated an	nd my child's conditi	on is stable; the	school nurse may	ng procedures. If the procedure is, at her discretion, teach unlicensed pendence in care if indicated.
School child atten	ds RUTH PARK	ER EASON		
Signature of Parer	nt or Guardian			Date
**	**************************************			**************************************
				Date of
Name of Student	Teat	Direct	XA Y	Birth
	Last	First	M.I.	Birth
Name of Student Diagnosis	Last	First	M.I.	Birth
Diagnosis	Last wing Treatment Proce			
Diagnosis I request the following Oxygen	wing Treatment Proce	dure be administe	red during school h	
Diagnosis I request the following Oxygen Utilize pulse distress	wing Treatment Proce liters/min (%) P e oximeter to measure	dure be administe RN for respirato e oxygen saturati	red during school h ry distress &/or oz on levels PRN for	ours: xygen saturation levels < %
Diagnosis I request the follow Oxygen Utilize pulse distress Please list any spe	wing Treatment Proce liters/min (%) P e oximeter to measure	dure be administe RN for respirato e oxygen saturati	red during school h ry distress &/or oz on levels PRN for ware of or any unus	ours: xygen saturation levels < % signs & symptoms of respiratory
Diagnosis I request the following Oxygen Utilize pulse distress	wing Treatment Proce liters/min (%) P e oximeter to measure	dure be administe RN for respirato e oxygen saturati	red during school h ry distress &/or oz on levels PRN for	ours: xygen saturation levels < % signs & symptoms of respiratory
Diagnosis I request the follow Oxygen Utilize pulse distress Please list any spe	wing Treatment Proce liters/min (%) P coximeter to measure cific precautions person	dure be administe RN for respirato e oxygen saturati onnel should be av	red during school h ry distress &/or oz on levels PRN for ware of or any unus	ours: xygen saturation levels < % signs & symptoms of respiratory ual effects that might be observed.
Diagnosis I request the follow Oxygen Utilize pulse distress Please list any spe	wing Treatment Proce liters/min (%) Procession of the precautions personal party and	dure be administe RN for respirato e oxygen saturati onnel should be av	red during school h ry distress &/or or on levels PRN for ware of or any unus and terminate	ours: xygen saturation levels < % signs & symptoms of respiratory ual effects that might be observed.

To Parents:				
The undersigned parent(s) (or guardi- personnel employed by either the An Department to see that said child rece	ne Arundel County		ne Anne Arunc	nereby request(s) Hel County Health S PRESCRIBED
Anne Arundel County Health Department must supply the school with performed. It is understood that the undersigned parent(s) or guardian, any personnel employed by either Department the undersigned parent personnel from any legal claim(s) with the treatment to the student.	rtment as a condition supplies for all properties for all properties administration of Anne Arundel Co (s) or guardian he	quired by the Anne on to its agreement occdures and be prostered solely at the the acceptance of tounty Public School reby agree(s) to re	Arundel Court to administer esent for the frequest of and the request to play or Anne Alelease the said	any treatment that the irst time a treatment is accommodation to the perform this service by arundel County Health I institutions and their
I understand that this procedure we uncomplicated and my child's cond personnel this procedure. School or h	lition is stable; the	school nurse may	, at her discre	etion, teach unlicensed
School child attends RUTH PAR	KER EASON			
Signature of Parent or Guardian				Date

PHYSICIAN'S S	SIGNED ORDER	FOR TREATMEN	T AT SCHOO	OL
Name of Student			Date of Birth	
Last	First	M.I.		
Diagnosis				
I request the following Treatment Pro	cedure be administe	ered during school h	ours:	
Clean or change tracheostomy				
Change SHILEY# Unc Tracheostomy as back up	uffed Tracheoston	y PRN for obstruc	tion. May us	e Shiley #
Please list any specific precautions pe	rsonnel should be a	ware of or any unus	ual effects that	might be observed.
Services should begin		and terminate		
Date	3			Date
	Physician Physician	ı's Signature		
Physician's Name (Printed)	Address			
	Phone		Dat	e

To Parents:		
The undersigned parent(s) (or guardian) of personnel employed by either the Anne Arund Department to see that said child receives S		AS PRESCRIBED
Anne Arundel County Health Department as parent must supply the school with supplies performed. It is understood that the treatment undersigned parent(s) or guardian. In considerant any personnel employed by either Anne A Department the undersigned parent(s) or guardian personnel from any legal claim(s) which they the treatment to the student.	V. It is required by the As a condition to its agreed for all procedures and but is administered solely a deration of the acceptance arundel County Public Superdian hereby agree(s)	Anne Arundel County Public Schools and ment to administer any treatment that the e present for the first time a treatment is t the request of and accommodation to the of the request to perform this service by chools or Anne Arundel County Health to release the said institutions and their
I understand that this procedure will be per uncomplicated and my child's condition is personnel this procedure. School or health per	stable; the school nurse	may, at her discretion, teach unlicensed
School child attends RUTH PARKER E	ASON	·
Signature of Parent or Guardian		Date

Name of Student		Date of Birth
Last F	irst M.I.	
Diagnosis		
I request the following Treatment Procedure b	e administered during sch	ool hours:
Oropharyngeal Suctioning PRN for in	acreased 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 Date	*	e
Physician's Name (Printed)	Address	
	Phone	Date