School Health Services Program

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Dear Parent/Guardian/Responsible Person and Physician:

Whenever possible, your child should take their medication during non-school hours. If medication is needed while in school, the following requirements must be met on the first day that the student is to receive medication:

1. The parent/guardian/responsible person (student or adult 18 years or older) must submit to the school nurse a completed Medication Plan, without deletions or changes. This will be kept on file in the Student's Health Record. You are responsible for obtaining the required medication information from a licensed health care provider. Medication will not be given without a completed Medication Plan.

2. A completed Medication Plan including the parent/guardian/responsible person's signed consent (part 1) and licensed health care provider's signed authorization (part 2) must be in place before the student can receive medication at school.

3. Medication Plans are effective 1 calendar year from the date signed by the licensed health care provider, unless noted otherwise.

4. The parent/guardian/responsible person shall submit a new Medication Plan to assigned Children School Services (CSS) personnel or the trained school employee whenever there is a change in the Medication Plan, to include medication strength, dose, route, time and frequency.

5. A separate Medication Plan shall be submitted for each medication to be given at school.

6. All prescription medication must be properly labeled by the pharmacist. The label must include:
    - Student's name,
    - Name and strength of medication,
    - Dose and time medication is to be given,
    - How the medication is given (or delivered) and
    - Date medication was prepared

7. Over-the-counter medication must be authorized by a licensed health care provider, must be received in the original manufacturer's container and labeled with the student's name. A pharmacy label is not required. Nurse will review these medications to ensure correct labeling, correct medication, and current date does not exceed the manufacturer's expiration.

8. The first day's dose of any new medication must be given at home.

9. Medications must be brought to school by the parent/guardian/responsible person and received by authorized personnel (a CSS employee or the trained school employee).

10. All medication kept in school will be stored in a secured area for only authorized a personnel. CSS and District of Columbia Public or Public Charter Schools personnel will not assume any responsibility for possible loss of student medication.

11. Within 1 week of the expiration of the medication or licensed health care providers Medication Plan, the unused portion of the medication must be collected by the parent/guardian/ responsible person or it will be destroyed.

12. School or CSS personnel will not assume any responsibility for unauthorized medication or medication to oneself by the student.

Government of the District of Columbia
Department of Health
Community Health Administration

MEDICATION PLAN

NAME OF STUDENT:_____ DATE OF BIRTH:_____

SCHOOL:_____ TEACHER/GRADE:_____

PART I: PARENT/GUARDIAN/RESPONSIBLEPERSON AUTHORIZATION AND CONSENT

Parent/Guardian/Responsible Person: Please complete and sign this section.

I hereby request and authorize CSS Personnel/Trained School Employee to administer prescribed medication as directed by the licensed health care provider to _____. This medication is a ____new (or) ____renewal prescription.
Name of Student

If new prescription, enter the date and time the first dose was given at home. Date:_____Time:_____a.m./p.m.

I hereby acknowledge that the District, and its schools, employees, and agents shall be immune from civil liability for acts or omissions under DC Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

_____ _____ _____
SIGNATURE OF PARENT/GUARDIAN/RESPONSIBLE PERSON RELATIONSHIP HOME PHONE

_____ _____ _____ _____
PLEASE PRINT NAME WORK/CELL PHONE E-MAILADDRESS DATE

PART II: LICENSED HEALTH CARE PROVIDER'S AUTHORIZATION FOR MEDICATION

Licensed Health Care Provider: Please complete and sign this plan. ___New ___Renewal ___Change

NAME OF STUDENT:_____ DATE OF BIRTH:_____

NAME AND STRENGTH OF MEDICATION:_____ DOSE/ROUTE:_____

TIME AND FREQUENCY AT SCHOOL:_____

DIAGNOSIS:_____

EXPECTED DURATION OF SCHOOL ADMINISTRATION:_____

Can a reaction be expected? ___YES ___NO If yes, please describe possible side effects:_____

Special instructions or emergency procedures:_____

Medication plans must be updated and the school nurse immediately notified when there is any change in the student's health or treatment requirements. Otherwise, DC law 17-107 requires that medication plans be updated annually.

_____ _____
LICENSED HEALTH CARE PROVIDER SIGNATURE OFFICE PHONE DATE

_____ _____
PLEASE PRINT NAME E-mail Address

Please use an office stamp or clearly print the names of any other Licensed Health Care Provider in your practice concurrently treating this student.
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Medication Plan authorization received by:

_____

Signature of CSS Personnel/Trained School Employee

_____

DATE

Revised 1-18-18

School Health Services Program
AUTHORIZATION FOR SPECIFIC MEDICAL PROCEDURE/TREATMENT

Dear Parent/Guardian/Responsible Person and Physician:

Students in need of medical procedures and /or treatments during the school day must meet the following requirements:

1. Parents/guardians/responsible person must present to the authorized CSS personnel a signed, completed Medical Procedure/Treatment Plan including the parent/guardian/responsible person signed consent (part 1) and licensed health care provider signed authorization for the procedure/treatment (part 2). The licensed health care provider's signed authorization and parent's signed consent will be maintained in the Student Health Record.

2. A separate Medical Procedure or Treatment Plan shall be submitted for each procedure or treatment to be given or performed at school.

3. The licensed health care provider's signed authorization must include:
   - Student's name and date of birth
   - Diagnosis, reason for procedure/treatment
   - Name of the procedure/treatment
   - Time the procedure/treatment is to be performed and/or frequency at school
   - Expected duration of treatment
   - Special instructions or emergency procedures

4. Supplies to give a medical procedure/treatment must be provided by the parent/guardian/responsible person (student or adult 18 years or older). All equipment and supplies that are required must remain in the school if possible.

5. Licensed health care provider signed authorization for medical procedures/treatments are valid for 1 year from the date signed by the provider.

6. If any adjustments (for example technique, frequency,) to the medical procedure/treatment plan are made, a new Medical Procedure/Treatment Plan is required.

7. All equipment and supplies kept in the school will be stored in a secured area accessible only to personnel giving or performing the treatment. CSS personnel and District of Columbia Public and Public Charter School personnel assume no responsibility for possible loss of or damage to equipment and supplies.

8. Within 1 week after expiration of the licensed health care providers Plan, or after any of the supplies expire, the parent/guardian/responsible person must collect the equipment and unused portion of the supplies. Expired supplies that are not collected by the parent/guardian/responsible person in that time frame will be destroyed.

9. CSS personnel and school personnel are not responsible for unauthorized procedures/treatments or those given to oneself by the student.

Government of the District of Columbia
Department of Health
Community Health Administration
MEDICAL PROCEDURE/TREATMENT PLAN

NAME OF STUDENT:_____ DATE OF BIRTH:_____

SCHOOL:_____ TEACHER/GRADE:_____

PART I: PARENT/GUARDIAN/RESPONSIBLE PERSON AUTHORIZATION AND CONSENT

Parent/Guardian: Please complete and sign this section.

I hereby request and authorize CSS Personnel and trained School Employees to administer the prescribed treatment as directed by the licensed Health Care Provider to _____ .

This treatment is a _____new (or) _____renewal treatment. If new treatment, enter the date and time the first treatment was given at home. Date:_____Time:_____a.m./p.m.

_____ _____ _____

SIGNATURE OF PARENT/GUARDIAN PHONE RELATIONSHIP

_____ _____ _____

PLEASE PRINT NAME WORK/CELL PHONE DATE

PART II: LICENSED HEALTH CARE PROVIDER'S AUTHORIZATION FOR TREATMENT

Health Care Practitioner: Please complete and sign this plan. ___New ___Renewal ___Change

NAME OF STUDENT:_____ DATE OF BIRTH:_____

TREATMENT:_____

TIME &FREQUENCY AT SCHOOL:_____

DIAGNOSIS:_____

EXPECTED DURATION OF TREATMENT: _____

Special instructions or emergency procedures: _____

_____

Treatment plans must be updated and CSS Personnel immediately notified when there is any change in the student's health or treatment requirements. Otherwise treatment plans are updated annually.

_____ _____

LICENSED HEALTH CARE PROVIDER SIGNATURE OFFICE PHONE DATE

_____ _____

PLEASE PRINT NAME EMAIL ADDRESS

_____ _____

Please use an office stamp or clearly print the names of any other Licensed Health Care Provider in your practice concurrently treating this student.

Treatment authorization received by:

_____

SIGNATURE OF CSS PERSONNEL

_____

DATE

Revised 1-18-2018