2017-2018

Wayne County School Health Services

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Student **Last**_____ **First**_____

DOB _____School_____Grade_____

Allergies:

Diagnosis ICD10	Attention Deficit Disorder F90.0		Asthma J45		Diabetes Mellitus E10		Seizure Disorder G40	
	A.D. Hyperactive Disorder F90.9		Other (specify & include code)				Other (specify & include code)	

I have prescribed the following medication or procedure for the above named student:

MEDICATION/PROCEDURE	Dosage/Instruction	Route	What Time(s) to give at SCHOOL	What Time(s) to give at HOME

ESTIMATED DURATION OF TX.	# Days ____	# Weeks ___	# Years _____	Indefinitely _____	Other _____

GOALS	Improve attention span		Reduce impulsiveness		Improve school performance		Other
	Control seizure activity		Control blood sugar level		Prevent respiratory distress		

RECOVERY POTENTIAL	Full ___	Fair ___	Other ___	COMMENTS:

If an Emergency **inhaler, epinephrine kit, or glucagon** is ordered, this student has been trained in its use, is responsible to use and keep unauthorized persons from accessing and may carry on his/her person at all times. (**Physician** please initial ___YES (or) ____ NO if applicable).	Physicians Name Address Phone

***Rx # & date filled from Rx label & date med received @ school is documented on MAR.**

Physician signature date reflects date authorized to give at school (first day of each school year or date of order if later).*

PHYSICIAN SIGNATURE (No Stamp Please) _____ **Date:** ____-____-_____

Reauthorization PHYSICIAN SIGNATURE _____ **Date:** ____-____-_____

PARENT AUTHORIZATION FOR SCHOOL MEDICATION / PROCEDURE ASSISTANCE

I understand that permission to assist this student with medications and treatments which are ordered by his/her physician will continue to be in effect for the school lifetime of my child until I (the parent/legal guardian) notify the school nurse that it is revoked or changed.

I hereby request and authorize the principal and his/her designees to **1)** administer or assist my child with the medication(s) or procedure(s) as prescribed by his/her physician and as directed on the label of the current original container I provided**. 2)** I also give permission for my child's physician(s) to release any medical records to my child's school health representative, **3)** for the school to release medically related records to my child's physician(s**), 4)** for the physician and school nurse to communicate regarding my child's care/progress during school hours **5)** for the school to bill my child's medical insurance for services rendered during school hours, and **6)** for the school to seek emergency medical services for my child if necessary. My child is covered under the following insurance program and I will attach a copy of his/her insurance card. (Please check one)

Blue Cross/Blue Shield___ Medicaid____PeachCare___ State Merit ___ Other _____ Insurance/Medicaid Number_____

I understand that the school system cannot provide these health related services to my child, or bill Medicaid/PeachCare or obtain information about my child without my consent for these health related services.

I have read this form and I understand that school personnel will administer the medication(s)/procedure(s) in accordance with school health procedures. I understand my responsibility toward the school personnel who are agreeing to assist me in this matter of medication for my child while at school. I will administer at least one dose of the medication(s) prior to any school administration of the medication. I agree that the school system and personnel will not be held legally responsible or liable for any illness or damage that may result from administration or lack of administration of this medication/procedure to my child or from the storage of medication supplies for my child. I agree to provide any supplies and equipment necessary to carry out this request.

If any information on this form CHANGES, it is my responsibility to notify the School Nurse.

*****IT IS DANGEROUS TO SEND MEDICINES TO SCHOOL BY A STUDENT - AN ADULT MUST BRING MEDICINES TO THE SCHOOL CLINIC*****

We can ASSIST WITH MEDICATIONS with a CURRENT DOCTOR'S ORDER AND CURRENT CORRECTLY LABELED CONTAINER ONLY.

I understand that if this medication, the dose or the frequency is changed or if this medication is discontinued, a new authorization or change form must be completed.

Date _____ Parent/Guardian Signature _____ Home/Cell Phone _____

Address _____ Work Phone _____

Emergency Contact Name _____Relationship _____ Phone _____