

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: <input type="checkbox"/> New; the first dose was given at home on date and time: _____ <input type="checkbox"/> Renewal <input type="checkbox"/> Change	
Is this a standing order? <input type="checkbox"/> Yes, epinephrine auto injector 0.15 mg: <i>refer to anaphylaxis plan</i> <input type="checkbox"/> Yes, other: _____	
<input type="checkbox"/> Yes, epinephrine auto injector 0.3 mg: <i>refer to anaphylaxis plan</i> <input type="checkbox"/> No	
<input type="checkbox"/> Yes, albuterol sulfate 90 mcg/inh: <i>refer to asthma action plan</i>	

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: <input type="checkbox"/> New <input type="checkbox"/> Renewal <input type="checkbox"/> 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:
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