MONTGOMERY COUNTY SCHOOLS: REQUEST FOR MEDICINE TO BE GIVEN DURING SCHOOL HOURS

School: _____ Telephone: _____ Fax: _____

Student Name_____ Birthdate_____
Teacher _____ Grade _____

In order to help protect your child's health, your consent and written authorization from a health care provider with prescriptive authority is required when it is necessary for your child to receive prescription and/or non-prescription medicines at school.

To Be Completed By Healthcare Provider:

Medication_____Dosage_____ Route _____

Medical Diagnosis: _____

How often and/or at what time (hour):_____

Purpose of medication: _____

Relationship to meals, if applicable: _____

Expected side effects or adverse reactions: _____

Specific indications: _____

To be given from date_____ to _____

Other information: _____

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

_____ _____ _____

Healthcare Provider Signature **Date** **Phone Number**

To be completed by Healthcare Provider for student who will self-carry/ self-administer medication:

The student must have the medication(s) listed above during the school day or at school sponsored events in order to function. **Adult Supervision is NOT needed.** The student has been instructed in the treatment plan and self-administration of the listed medication(s) and has demonstrated the skill level necessary to self-administer medications for:

☐ Asthma ☐ Severe Allergy ☐ Diabetes ☐ Other _____

For Epinephrine Auto Injector Only:

In the event the student is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector, the school nurse will train designated school staff to administer the Epinephrine Auto Injector and call 911.

_____ _____

Healthcare Provider Signature **Date**

******Parent signature needed on back of form**********

Parent or Guardian's Permission:
I give permission for my child to receive this medicine during school hours. I also give permission for school staff to contact the prescribing healthcare provider with questions/concerns. I understand that it is my responsibility to purchase and supply this medicine in its original container. On behalf of my child I absolve the Montgomery County School Board and their agents and employees from any and all liability whatsoever that may result from my child taking this medicine at school.

________________________	__________	__________________________________
Parent/Guardian Signature	**Date**	**Contact numbers (home telephone, cell phone)**

To be completed by Parent/Guardian for student who will self carry/ self administer medication:

I request and give permission for my child to carry and give the medication listed on the reverse side of this form during the school day, at school-sponsored activities or while in transit to or from school. Adult supervision is not needed. I understand that:

- I shall provide the school back-up medication (in addition to what my child will carry) that shall be kept at school.
- My child will be required to demonstrate the skill level necessary to use the self-administered emergency medication to school staff trained by the school nurse.
- My child will be subject to disciplinary action if medication is used in any other manner than prescribed.
- The Montgomery County School board of education and its employees and agents are not liable for injury arising from the student's possession and self-administration of the medication

For Epinephrine Auto Injector Only:
In the event my child is experiencing respiratory difficulty and is unable to administer the Epinephrine Auto Injector ordered by the physician, a trained school staff member may administer the Epinephrine Auto Injector and call 911. I have observed my child demonstrate the necessary skill level to implement the care plan prescribed by his/her health care provider.

Parent/Guardian Signature ____________________________________ Date _________

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To Be Completed By Student At School who will self carry/ self administer medication:

- ☐ I have demonstrated use of my medication for the school staff listed.
- ☐ I plan to keep my medication and equipment with me at school
- ☐ I will use my medication as advised by my physician.
- ☐ I will not allow any other person to use my medication.
- ☐ I will notify a school staff member if I am having more difficulty than usual with my medication

Student Signature ______________________________________ Date _____________

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To be completed by School Nurse:
I have observed the student indicated above verbalize and demonstrate the skill level necessary to use the medication prescribed by the above physician.

☐ Inhaler ☐ Epinephrine Auto Injector ☐ Insulin ☐ Other __________________________

Nurse Signature ____________________________________ Date _______________

Date Received/ By: ___________________ School Nurse Reviewed/Date:________________________

Location of Medication: ☐ In Health Room ☐ In Classroom ☐ with student, emergency medication only