

**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/RESPONSIBLE PERSON AUTHORIZATION AND CONSENT

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

I hereby request and authorize the School Nurse /Trained School Employee to administer prescribed medication as directed by the licensed practitioner 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-MAIL ADDRESS DATE

PART II: LICENSED PRACTITIONER'S AUTHORIZATION FOR MEDICATION

Physician/Nurse Practitioner: Please complete and sign this plan. ___ New ___ Renewal ___ Change

NAME OF STUDENT: _____ DATE OF BIRTH: _____

NAME 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 requires that medication plans be updated annually.

 LICENSED PRACTITIONER SIGNATURE OFFICE PHONE DATE

 PLEASE PRINT NAME E-mail Address

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

Medication Plan authorization received by:

 Signature of CSS Nurse/Trained School Employee

 DATE