# Spring Creek ISD Medications/Treatment Request

THE FOLLOWING MUST BE MET IN ORDER TO ADMINISTER PRESCRIBED MEDICATION OR SPECIAL HEALTH CARE PROCEDURE BY SCHOOL PERSONNEL:

1. Treatment of prescribed medications will be administered during school hours only when ordered by the physician.
2. The information requested below must be complete. The parent/guardian requesting the treatment and/or medication must sign this form. A separate form must be completed and submitted for each treatment or medication.
3. Parent/Guardian should deliver the identified medication/treatment supplies to the main office, along with this completed and signed form.
4. Medications must be delivered to the main office in their original, properly labeled containers. Prescription medications must be labeled with the name and address of the pharmacy, name of student, name of prescribing practitioner, date the prescription is dispensed, instructions for use an expiration date of medication.(You may ask your pharmacist for a second, properly labeled bottle so you have one for home and school.)
5. Certain medications/treatments require specific care plans. Administration is responsible for the administration of that care plan through direct care or supervision. Therefore, the administration may contact the physician for institution of the care plan or order clarification and the physician may disclose any information concerning that student to the school nurse or other representative of Spring Creek ISD.
6. Please complete the following:

Name of student:_____ Birthdate:_____

Address:_____ Campus:_____ Grade:_____

Home Phone:_____ Emergency Phone:_____

Medication Allergies:_____ Food/Environmental Allergies:_____

Prescribed Medication/Treatment:_____ Dosage:_____

Diagnosis:_____ Time(s) of Administration:_____ Route:_____

Date of Request:_____ Termination Date of Medication/Treatment:_____

Precautions/Unfavorable Reactions:_____

IF SPECIFIC MEDICATION IS AN INHALER PLEASE ADDRESS THE FOLLOWING:

A.) Inhalers are kept locked in the clinic/office to facilitate accessibility of inhaler and monitoring of student's condition, but if due to medical necessity does physician permit student to carry inhaler on him/herself during school hours? (circle) yes no

B.) Has student been instructed on the safe use of the inhaler? (circle) yes no

C.) Is student able to self- administer his/her inhaler? (circle) yes no

IF SPECIFIC MEDICATION TO BE ADMINISTERED BY NEBULIZER ADDRESS THE FOLLOWING:

A.) Is student permitted to keep nebulizer in the clinic? (Circle) yes no

B.) Has student been instructed on the use of the nebulizer? (Circle) yes no

C.) Is the student able to self-administer his/her nebulizer? (Circle) yes no

D.) Please address care and maintenance of nebulizer after treatment:_____

Physician's name (printed)_____ Physician Phone:_____

Physician's signature:_____ Physician's Office FAX:_____

Parent/Guardian to Complete This Section

I the undersigned legal parent/guardian of the above named student request the medication or procedure described above be administered to my child during school hours. I fully understand that trained NON-MEDICAL personnel may administer the medication, procedure or treatment to my child.

Parent/Guardian Signature:_____ Relationship:_____