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/RESPONSIBLEPERSON AUTHORIZATION AND CONSENT

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

I hereby request and authorize CSS Personnel/Trained School Employee to administer prescribed medication as directed by the licensed health care provider 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-MAILADDRESS DATE

PART II: LICENSED HEALTH CARE PROVIDER'S AUTHORIZATION FOR MEDICATION

Licensed Health Care Provider: Please complete and sign this plan. ___New ____Renewal ____Change

NAME OF STUDENT:_____ DATE OF BIRTH:_____

NAME AND STRENGTH 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 17-107 requires that medication plans be updated annually.

_____ _____
LICENSED HEALTH CARE PROVIDER SIGNATURE OFFICE PHONE DATE

_____ _____
PLEASE PRINT NAME E-mail Address

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

Medication Plan authorization received by:

_____

Signature of CSS Personnel/Trained School Employee

_____

DATE

Revised 1-18-18