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 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-MAILADDRESS 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 School Nurse/Trained School Employee

_____
DATE

Revised 8-1-15