COMMISSION LEADERSHIP ACADEMY

Commission Leadership Academy
Form 1702 Parent Request and Physicians' Order Form for Medication

Student Name: **DOB:** **School:** **School Year:**

	Diagnosis	Name of Medication (**Right** Medication)	Dosage (**Right** Amount)	How to give (**Right** Route)	Time(s) to Give (**Right** Time)	Medication Log Date/Staff Signature 1	2	3	4	5
Daily Medication(s)	☐ ADHD ☐ Cystic Fibrosis ☐ Seizure ☐ Diabetes ☐ Other: _____									
Emergency Medication(s)	Allergy Allergen: _____	☐ Diphenhydramine (Benadryl)	☐ 12.5 mg ☐ 25 mg ☐ Other: _____	By Mouth	☐ Upon Exposure ☐ Mild Reaction					
		☐ Epinephrine Auto Injector	☐ 0.15 mg ☐ 0.3 mg	Intramuscular (IM)	☐ Upon Exposure ☐ Severe Reaction ☐ If provided, repeat dose after _____ min for continued symptoms.					
	Seizures	☐ Diastat Gel	☐ 5.0 mg ☐ 7.5 mg ☐ 10.0 mg ☐ _____ mg	Rectal	☐ At onset of seizure ☐ After 5 minutes ☐ After 10 minutes					
	Diabetes	☐ Glucagon	☐ 0.5 mg ☐ 1.0 mg	☐ Subcutaneous (SQ) ☐ Intramuscular (IM)	If student becomes unconscious					
Asthma	Exercise Induced Asthma	☐ Albuterol ☐ Xopenex	☐ 2 puffs ☐ 1 vial (ampule)	☐ Inhaler with spacer, if provided ☐ Nebulizer	Before exercise as needed to prevent symptoms					
	Asthma Yellow Zone	☐ Albuterol ☐ Xopenex	**Please check one** ☐ 2 puffs ☐ 4 puffs ☐ 1 vial (ampule)	☐ Inhaler with spacer, if provided ☐ Nebulizer	☐ Every 4 hours as needed to relieve symptoms ☐ _____					
	Asthma Red Zone		**Call 911** ☐ 4 puffs ☐ 1 vial (ampule)	☐ Inhaler with spacer, if provided ☐ Nebulizer	**For Emergency Symptoms**					
As Needed PRN Meds										

MD Stamp below

Physician Printed Name: _____ **Date:** _____ **Telephone:** _____

Physician Signature: _____ _____ **Fax:** _____

To be completed by parent:

I understand that:

- Non-medical personnel conduct the medication administration.
- It is my responsibility to have an adult transport the medication to school.
- If medication is not available at the school, 911 will be called for emergencies.
- If my child participates in before/after-school activities/sports, I will assume responsibility for contacting the advisor/coach of my child's medical condition. I will provide extra emergency medications that may be needed during the activity.

I request that:

- My child be administered the medication as indicated in the physician's order.
- If an emergency injection is ordered, I give permission for a school nurse to instruct designated staff in the administration technique.

I authorize:

- The release and exchange of medical information between my child's physician and Commission Leadership Academy (CLA) that is necessary in carrying out services for my child.

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician.

I hereby release the CLA Board of Directors and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Parent/Guardian Signature: _____ **Date:** _____ **Phone:** _____ **Phone :** _____

Student Self-Carry and Self-Administration of Emergency Medication

To be completed by Physician:

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

☐ Asthma ☐ Allergy ☐ Insulin Other: _____

For Epinephrine Auto Injector Only:

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

Printed Physician's Name: _____

Physician's Signature: _____ **Date:** _____

To be completed by student at school:

☐ I have demonstrated the use of my medication to the school staff listed.
☐ I plan to keep my medication and equipment with me at school.
☐ I will use only as prescribed by my doctor.
☐ 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 health condition.

Student Signature: _____ **Date:** _____

To be completed by Parent:

- I request and give permission for my child to carry and give the medication listed on the reverse side 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 student will carry) that shall be kept at school.
- My child will be required to demonstrate the skill level necessary to use the self-administered medication to the primary medication administrator.
- My child will be subject to disciplinary action if medication is used in any other manner than prescribed.

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 Signature: **Date:**

To be completed by primary medication administrator:

I have observed the student indicated above verbalize and demonstrate the skill level necessary to use the medication prescribed by the above physician.

☐ Epinephrine Auto Injector ☐ Inhaler

Signature: **Date:**