Coeur d'Alene Public Schools

MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION) REQUEST FORM

SCHOOL YEAR ______ - ______

STUDENT NAME: ____ **Birthdate:** _______________

SCHOOL: ____ **Grade:** ________________

THIS PORTION TO BE COMPLETED BY LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Attach prescription(s) or additional sheet(s) if necessary to provide requested information and medical authorization.

- ❑ Clean Intermittent Catheterization Cath Size : _____ Fr.
- ❑ Central Line or PICC
- ❑ Dressing Change
- ❑ Ostomy Care
- ❑ Chest Clapping
- ❑ Percussion
- ❑ Postural Drainage
- ❑ Tracheostomy Care Trach Size: ______
- ❑ Trach Suctioning Cath Size: _____ Fr.
- ❑ Trach Replacement – specify below
- ❑ Oxygen Administration – specific below
- ❑ Pulse Oximetry monitoring
- ❑ Other: ________________________________

Student will also require treatment during: ❑ transport ❑ school-sponsored trips ❑ before/after school programs

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Student Skill Level (select the most appropriate option):

❑ Nurse-Dependent Student: nurse must administer treatment
❑ Supervised Student: student self-treats under adult supervision
❑ Independent Student: student is elf-carry/self-treat (initial below)

[ ] I attest student demonstrated the ability self-administer the prescribed treatment effectively for school/field trips/school sponsored events.

LHP's Initials

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1. Diagnosis:____Diagnosis is self-limited: ❑ Yes ❑ No
2. Treatment required in school
   □ Oxygen administration: _________ (Amount (L)) ______ (Route) □ _____________________ (Frequency/specific time(s) of administration) □ prn □ O2 Sat < ______% □ __________ (Specify Symptoms)

   □ Other Treatment: ______________________ (Treatment Name) __________ (Route) _____________________ (Frequency/specific time(s) of administration) □ prn ________________ (Specify Symptoms)

   □ Additional Instructions or Treatment: ____
3. Conditions under which treatment should not be provided: ____________________________________
4. Possible side effects/adverse reactions to treatment: ____
5. Specific instructions for nurse (if one is assigned and present) in case of adverse reactions, including dislodgement or blockage of tracheostomy: ____
6. Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy:

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I request/authorize the above named student be administered the above named treatment in accordance with the instructions indicated above from ________________________ to __________________ or the entire school year including summer months (if applicable), as there exists a valid health reason which makes the treatment advisable during school hours. **Orders are valid for the current school year only.**

Date of Signature: ___________________ **Licensed Health Professional's Signature**: ______________________________

Phone #: ______________________ Fax: ______________________ LHP's Name (print): ______________________________

NEXT PAGE TO BE COMPLETED BY THE PARENT/GUARDIAN

This record must be maintained by the school district for 5 years.

Coeur d'Alene Public Schools

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I have read and understand the parent information regarding medication at school (school office) and request/authorize trained school staff to care for my child in accordance with the LHP's instructions above for the dates of _________________ to ___________________ or one entire school year including summer months (if applicable). Orders are valid for the current school year only.

I understand that I must provide all necessary supplies and equipment to perform this service. I understand that the procedure will not begin until adequate training of qualified staff is completed. I will notify the school immediately with any changes or cancellations. I will collect any necessary supplies and equipment from the school at the end of the year or understand that it will be discarded. I give my permission for the exchange of information between school district nurse and Licensed Health Professional for the purpose of clarifying orders/concerns that could affect safe administration at school.

FOR SELF-TREATMENT (INDEPENDENT STUDENTS ONLY)

I certify/confirm that my child has been fully trained and can perform treatments on his or her own. I consent to my child carrying, storing and giving him or herself the treatments prescribed on this form in school. I am responsible for giving my child these supplies and equipment labeled as described above. I am also responsible for monitoring my child's treatments, and for all results of my child's self-treatment in school. The school nurse will confirm my child's ability to perform treatments on his/her own. I also agree to give the school clearly labeled "back up" equipment or supplies in the event that my child is unable to self-treat.

Date of Signature: _________________ Parent/Guardian Signature ____

Home Phone: __________________ Work/Cell Phone: _________________ Alternate Phone: ______________________________________

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