PARENT NEED TO COMPLETE THIS FORM:

StudentName:_____DOB/Grade:_____School Year:_____

Homeroom Teacher:_____ _____Diagnoses: _____ADHD_____

Nursing Diagnosis (ND)	Nursing Intervention	Nursing goals/outcomes
1.Potential for impaired educational, social, and coping skills r/t adhd 2.Potential need for medication for management for adhd	*Family, teachers, and other staff will be provided info and support as it relates to adhd when needed. *Encourage student to maintain medication regimen prescribed by MD. If MD orders the medication during school hours, student will come to the office to be observed and/or assisted with medication to be given per MD orders. *Student will be monitored for potential side effects.	*The student will increase optimum participation educational program *Student will cooperate with medical tx (including taking medication as ordered by MD) plan during the school day. *Student will not experience any side effects while taking medication ordered by MD.

I_____(parent/guardian) authorize the school administration to designate school personnel(s) (who will not need a medical or nursing licenses),or the school nurse to assist/observe my child taking the prescribed medication which is (name of medication)_____ and to perform and carry out the care as outlined in (student's name)_____ Individualized Healthcare Plan. I also consent to the release of the information contained in this Individualized Healthcare Plan to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I consent to communication between the prescribing physician, the Pharmacist, the school nurse, and the designated school personnel (which is assigned by the school administration) necessary for the management and administration of medications pertaining to my child's medical condition addressed on this Individualized Healthcare Plan.

Parent/guardian Signature:_____Date_____Phone#_____

Emergency contact person(s) 1. _____ Phone# _____

2. _____Phone#_____

FORM A
MEDICATION ADMINISTRATION FORM
ADHD

PERRY COUNTY SCHOOL DISTRICT

PARENT AUTHORIZATION AND INDEMNITY AGREEMENT/MEDICATIONS RELEASE:

The undersigned parent/s or guardian/s of _____, a minor child, has requested personnel(s) of the Perry County School District to administer the prescribed medicine by a physician to this student. This request has been made for my/our convenience as a substitute for parental administration of this medicine. It is understood that the school administration will designate a school personnel(s) (who will not need a medical or nursing licenses) &/or school nurse to assist/ observe my child taking the prescribed medicine ordered by a physician. I/We forever release, discharge and covenant to hold harmless the school district, its personnel and board of trustees from any claims, demands, damages, expenses, loss of services and cause of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from the administration of the prescription medicine. The unsigned agree to repay the school district, its personnel or trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any injury to the minor child as a result of the administration of medicine. I have read the foregoing release and indemnity agreement and fully understand it. Executed this the _____day of _____, 20_____.

_____ _____

Signature of Parent/Guardian **Witness**

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name:_____ DOB/Age_____ Grade _____

School_____ Teacher_____ School year_____

HT_____WT_____ Allergies/Reactions_____

I request my child name and identified above to receive:

_____ Medication as prescribed by our physician on the form below or as listed on the container issued by the pharmacy.

_____Non-prescription/over-the-counter medication provided by me along with Dr.'s order

I understand and consent to the release of the information to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I consent to communication between the prescribing physician, the Pharmacist, and the school nurse, necessary for the management and administration of medications pertaining to my child's medical condition. I authorize the school administration to designate a school personnel(s)(who will not need a medical or nursing licenses) or school nurse to assist/ observe my child taking the prescribed medication ordered by a physician that is listed below. I understand that Perry County school district is rendering a service and does not assume any responsibility for this matter.

Name of medication_____

Signature of Parent/Guardian_____Date_____phone#_____

Emergency Contacts: Name:_____ Phone#_____

PRESCRIBER AUTHORIZATION (TO BE FILLED OUT BY THE DR.)

StudentName:_____DOB_____Allergies:_____

Name of Medication_____ Strength [**# milligrams(MG**)]_____

Dosage **[# of pills to take/ liquid to take**]_____ Route:_____

Frequency (**Time to be given at school)_____**

Date to begin medication:_____ Date to stop med._____

Reason for taking the medication:_____

Potential side ffects/adversereactions:_____

Any special instructions or Recommendations: _____

Physician Signature:_____ Physician Name: _____

Name of Clinic:_____ Date:_____ Phone #_____