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| **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 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** |

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| **TO BE COMPLETED BY PARENT/GUARDIAN** Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB/Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M/F School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_\_\_\_\_\_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 orderI 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, & the school nurse 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 listed medication 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#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **PRESCRIBER AUTHORIZATION (To be filled out by the Dr. only)**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 edication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Potential side ffects/adversereactions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any special instructions or Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

 **Parent to fill out back page see (Page 4)**

**PARENT NEED TO FILL OUT THIS FORM:**

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB/Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Homeroom Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnoses: SEIZURES\_\_\_\_\_ \_\_

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| Nursing Diagnosis(ND) | Nursing Intervention | Nursing goals/outcomes |
| 1. Potential for injury r/t uncontrolled movements of sz activity. Student has hx of sz. | \*Monitor for sz activity & tx as per MD order.\* Have sz action plan on file.\* If sz activity follow the below:Follow action plan & MD order, Stay with the student & stay calm, Call 911 and parents, monitor the date, time, duration of sz. Don’t restrain student, don’t put anything in mouth, stay with student at all times, protect head, keep airway open, turn on side, first aid care as needed. | \*Student will not experience an injury during a sz.\*Student will maintain healthy and well-being necessary for learning and action plan will be on file.  |

List Seizure type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. How long does it last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How often does it happen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Description:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List seizure triggers or warning signs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student reaction to seizure:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(parent/guardian) authorize for 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 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 health care provider, the school nurse, and the designated school personnel(s) (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 Contacts:** 1. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_