|  |
| --- |
| **PERRY COUNTY SCHOOL DISTRICT 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 prescription 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 license) to assist&/or 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 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, & the school nurse necessary for the management and administration of medications pertaining to my child’s medical condition. I authorize the school nurse &/or the school administration to designate a school personnel(s)(who will not need a medical or nursing license) to assist &/or observe my child taking the prescribed medication order 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  **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 [**Total # 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 #\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**PARENTS TO FILL OUT BACK PAGE (SEE PG 3)**

**\*Parent need to complete this form:**

StudentName:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB/Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School Year:\_\_\_\_\_\_\_\_\_\_

Homeroom Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnoses:  **DIABETES**  \_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Nursing Diagnosis  (ND) | Nursing Intervention | Nursing goals/outcomes |
| 1. Potential for diabetes emergencies. Risk for unstable blood glucose. | \*Monitor /Encourage student to maintain glucose within goal range.  \*Monitor blood glucose per MD order.  \*Administer Insulin per MD order  \* Monitor and treat hypo/hyperglycemia per MD order  \*Have Diabetes Action plan on file. | \*Student will maintain blood glucose with goal range.  \*Student will maintain healthy and well-being necessary for learning and action plan will be on file. |

**List Diabetes type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Please circle the equipment used: Insulin pen, Insulin pump, or Syringe and vial.**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(parent/guardian) give permission to the school nurse and/or give authorization to the school administration to designate a school personnel(s)( who will not need a medical or nursing license) to assist or 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 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. Pleases fill out the below with at least 2 Emergency contact names and phone numbers.

**Parent/guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Name 1. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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