



Government of the District of Columbia
Department of Health
Community Health Administration



MEDICATION PLAN

NAME OF STUDENT: _____ DATE OF BIRTH: _____
SCHOOL: _____ TEACHER/GRADE: _____

PART I: PARENT/GUARDIAN/RESPONSIBLE PERSON AUTHORIZATION AND CONSENT

Parent/Guardian/Responsible Person: Please complete and sign this section.

I hereby request and authorize CSS Personnel/Trained School Employee to administer prescribed medication as directed by the licensed health care provider to _____ Name of Student. This medication is a ___new (or) ___renewal prescription.

If new prescription, enter the date and time the first dose was given at home. Date: _____ Time: _____ a.m./p.m.

I hereby acknowledge that the District, and its schools, employees, and agents shall be immune from civil liability for acts or omissions under DC Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

SIGNATURE OF PARENT/GUARDIAN/RESPONSIBLE PERSON RELATIONSHIP HOME PHONE
PLEASE PRINT NAME WORK/CELL PHONE E-MAILADDRESS DATE

PART II: LICENSED HEALTH CARE PROVIDER'S AUTHORIZATION FOR MEDICATION

Licensed Health Care Provider: Please complete and sign this plan. ___New ___Renewal ___Change

NAME OF STUDENT: _____ DATE OF BIRTH: _____

NAME AND STRENGTH OF MEDICATION: _____ DOSE/ROUTE: _____

TIME AND FREQUENCY AT SCHOOL: _____

DIAGNOSIS: _____

EXPECTED DURATION OF SCHOOL ADMINISTRATION: _____

Can a reaction be expected? ___YES ___NO If yes, please describe possible side effects: _____

Special instructions or emergency procedures: _____

Medication plans must be updated and the school nurse immediately notified when there is any change in the student's health or treatment requirements. Otherwise, DC law 17-107 requires that medication plans be updated annually.

LICENSED HEALTH CARE PROVIDER SIGNATURE OFFICE PHONE DATE
PLEASE PRINT NAME E-mail Address

Please use an office stamp or clearly print the names of any other Licensed Health Care Provider in your practice concurrently treating this student.

Medication Plan authorization received by:

Signature of CSS Personnel/Trained School Employee

DATE