Request for Dispensing Medication During School Hours

Please complete the following information if medication (prescription or non-prescription) is to be administered during school hours.

Name of Student:__________________________________School:_________________________

Date of Birth:______________________Grade:_________________________

-To Be Completed By Your Child's Physician-

Diagnosis for which medication is necessary: MIGRAINES/HEADACHES_____________________

Name of Medication:____

Dosage:____

Time to be administered:____

If medication is to be administered PRN, please list under what conditions it should be given and how often it may be repeated.____

Length of time student will require medication:____

Are there any restrictions?____________If yes, what and for how long? ___________________

____

Is it necessary that this medication be given during school hours?_________________________

Physician's Signature:____Date:_________________

Print name of Physician:______________________________________Phone #:______________

-To Be Completed By Parent/Guardian-

I give permission for my child to receive the above medication during school hours as directed on this form by my child's physician.

Signature of Parent: ____Date:_____________

Home/Cell #: ___________________________________Work #:__________________________

HEALTHCARE PLAN
MIGRAINES

NAME: ______________________________________ **DOB:** ________________________

MEDICATION: ____

DATE: ____

NURSING DIAGNOSIS:

1. Pain related to migraine symptoms
2. Risk for absences due to migraine symptoms

GOALS: The student will:

- Seek treatment for migraines at first sign of an attack
- Comply with prescribed treatment plan

The family will:

- Provide school with medical treatment plan
- Supply appropriate prescribed medications

INTERVENTIONS:

1. Assess student for migraine symptoms
2. provide prescribed medication
3. Support student/family in exploring alternate treatment options
4. Assist student to identify possible triggers
5. Modify environmental factors that may contribute to student's discomfort

EVALUATION:

The student demonstrates good school attendance
The student reports an improved level of comfort after Interventions

COMMENTS:____
____
____

School Nurse__________________________________ **Parent/guardian**__________________
Date Date