# 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: _____

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**♦To Be Completed By Your Child's Physician♦**

Diagnosis for which medication is necessary: _____

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? _____

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

Physician's Signature: _____ Date: _____

Print name of Physician: _____ Phone #: _____

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**♦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/Guardian: _____ Date: _____

Home Phone #: _____ Work Phone #: _____

**INDIVIDUAL HEALTHCARE PLAN**
**ADHD/ADD**

**NAME:**_____ **DOB:**_____

**MEDICATION:**_____

**DATE:**_____ **GRADE:**_____

**NURSING DIAGNOSIS:**

1. Potential for impaired educational, social, and coping skills related to ADHD/ADD
2. Potential need for medication for management for ADHD/ADD.
3. Potential for an imbalance in Nutrition.

**GOALS:**

1. Student will increase optimum participation in education Program.
2. Student will cooperate with prescribed medical treatment plan during the school day.
3. Student will maintain a healthy diet and weight.

**INTERVENTION:**

1. Student will be given information and health counseling as needed.
2. Family, teachers, and other staff will be provided information, consultation and support as it relates to ADHD/ADD when needed.
3. Student will come to nurse's office for supervised administration of medication as indicated on Authorization of Medication Form that is signed by doctor and parent.
4. If student does not come to the nurse's office during scheduled time for medication the nurse will contact student to remind them.
5. Observe and report any unusual side effects.
6. Parent will supply medication in compliance with school policy and have the Medication Authorization form completed by them and the physician.
7. Observe for decrease appetite, and weight loss.
8. Discuss with student and family the importance of a Healthy diet and encourage student to pack lunch or review foods on school menu to have that are appealing to student.

**EVALUATION:**

The student is participating educationally, socially, and is using good coping skills for a positive learning experience. Student is cooperating with their prescribed medical plan. Student is eating healthy and maintaining a healthy weight.

**COMMENTS:**_____

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**School Nurse**_____ **Parent/Guardian**_____

Date Date