Other Health Condition Individual Health Plan School Year: _____ Grade: ___

Student Name_____DOB_____
Parent/Guardian_____Phone_____
Emergency Contact_____Phone_____
Treating Physician_____Phone_____

Type of Health Condition:

❒ Migraines ❒ Cardiac / Heart **Other: Please Specify**
❒ Stomach/Bowel ❒ Cancer
❒ Metabolic Disorder ❒ Blood Disorder
❒ Immune Disorder ❒ Joint or Bone

Known Triggers: Please Specify

Symptoms of Health Crisis: (What to look for at school)

ACTION:
1. Administer Medication as prescribed
2. Other: _____
3. Contact the parent/guardian as per their instructions: _____
_____

If student is unconscious or in severe crisis call for EMS.
CALL 911

OVER THE COUNTER MEDICATIONS AUTHORIZED BY PARENT/GUARDIAN Parents MUST provide all medications and supplies.

My child requires over-the-counter medication **provided by me**, the undersigned parent/guardian, as needed for symptoms of his/her diagnosed health condition DESCRIBED IN DETAIL ABOVE.

OTC Medication: _____ Dosage: _____
OTC Medication: _____ Dosage: _____

Prescription Emergency Medication: _____

Location of medication: ❒ Health Unit ❒ Emergency Medication must be with student at all times, or with an accompanying adult

Please Note: *The school nurse is not always available on field trips or during after school events/clubs/athletics. For this reason non-medical, unlicensed school staff members are trained to administer medication.*

Prescription medication or treatment daily <u>at school</u> for this condition: _____

Prescription medication or treatment daily <u>at home</u> for this condition: _____

During a field trip, scheduled daily medication:
❒ requires a trained staff member to administer medication
❒ is authorized to carry and self administer medication

X _____ _____ _____

Physician or Authorized Healthcare Provider Signature ***Telephone Number*** ***Date Signed***

I am the parent/guardian of the above named student and give consent and permission for the information on this form to be shared with teachers, principals, and other school personnel that have direct contact with my child for the current school year. I understand that a trained staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. If my child's physician gives authorization for my child to carry and self-administer his/her medication, I consent and understand that medication independently self administered is not monitored by school or health department staff. I agree to provide the necessary prescribed medication or treatment supplies and agree to notify the school nurse immediately of any changes.

The school nurse shall contact the student's Parent/Guardian to discuss any concerns regarding the student's care which might require medical follow-up and/or shall contact the health care provider to obtain current information verbally when necessary to manage the student's condition at school. I understand that the Powell County Board of Education Medication Policy and Procedures (09.2241) are readily available for me to read.

I hereby agree to release and hold Powell County Schools free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment described by me or prescribed by my child's physician. I have read and understand this consent. I sign it voluntarily and with full knowledge of its significance.

X _____ _____

Parent/Guardian Signature ***Date Signed***