Yellow Springs Schools

Request for Assistance with Prescribed Medical Treatment-Interventions-Equipment

*** Some students are able to attend school only with the administration or use of necessary medical treatments, equipment or interventions.
*** Parents are required to provide all equipment needed for the performance of any treatments.
*** If possible, all treatments should be performed under the supervision of the parent/guardians outside of school hours. When this is not possible, school personnel may perform required treatments when COMPLETE documentation of all information as requested from a physician/licensed prescriber, AND parent/guardian is received. These treatments MUST fall WITHIN THE SCOPE of PRACTICE of employed school staff if possible.
*** ALL information on this form MUST be completed PRIOR to the start of any health care treatments/interventions/use of equipment in school.
*** **ONLY ONE treatment/intervention/equipment PER FORM!!!**

Student Name	Grade / Teacher:
Address	Allergies:
Home number	Parent/Guardian Daytime number:

INFORMATION from PRESCRIBED PROVIDER:

The following treatment/intervention/equipment needs to be administered DURING the SCHOOL HOURS and is being prescribed for that time. I understand that unlicensed school personnel may be assisting the child with this treatment/intervention/equipment. This treatment/intervention/equipment has already been performed for this child and there has been no untoward reaction to the treatment/intervention/equipment. School personnel are not liable for effects related to the use of this treatment/intervention/equipment.

***** Please attach any additional needed instructions on the performance of the treatment, intervention or equipment.**

NAME of treatment/intervention/equipmen (ONLY ONE PER form)	
EQUIPMENT needed	
SCHOOL TIMES/INTERVALS for treatment/intervention/equipment use	
DIRECTIONS for treatment/intervention/equipment use	
If AS NEEDED, give SPECIFIC indications for when this treatment is to	
ADVERSE REACTIONS to report to provider	
Other special instructions including RESTRICTIONS to normal school activities related to this treatment/intervention/equipment use	

START date:	END date:
PRESCRIBER (print): Name: Address: Telephone number:	Prescriber's Signature:

Parent / Guardian Authorization:

I request that the treatment/intervention/equipment prescribed be administered to the student. I agree to submit in writing a revised statement in the event that any of the required information should change. I give permission for the principal and/or school nurse to contact the health care provider regarding the administration of this treatment/intervention/equipment in the school setting. I agree to deliver the needed equipment and/or supplies to the school in a timely manner. I agree to pick up any remaining medication within THREE days of the termination of administration and/or the end of the school year; if not, school staff will dispose of medication.

Parent/Guardian Name (print) Signature: Date:

SCHOOL USE ONLY
Request Accepted:
Request Denied/Reason:

Individual(s) Authorized to assist with medication administration:

Signature of Principle: Date:

Signature of School Nurse: Date:

- [ ] MEDICATION in Med Drawer
- [ ] FIELD TRIP list updated
- [ ] ANNUAL staff training
- [ ] DASL updates