Achieve Academy – Medical Forms

Student Name: _____ Date of Birth _____
Parent Name(s): _____
Healthcare Provider: _____

1. Self-Administration of Asthma Medicine by Minor Child at School

I, _____, Parent/Legal Guardian of the above-named student hereby request authorization for self-administration and possession of asthma medication by this student while in school, at a school-sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school-operated property. The student demonstrates full understanding of the proper use of his/her asthma medication.

I understand that:

Achieve Academy ("the school") and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication; b) the student's use, misuse, overuse, or neglected or failed use of his or her asthma medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty asthma medication and asthma devices.The school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with asthma medication. • the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self- administration of asthma medication, and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.

I take sole responsibility for:

• the monitoring of asthma medication, medication use, and refilling of prescriptions for asthma medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered asthma medication.

• ensuring the student always carries his/her asthma medication on his/her person.

• deciding if back-up medication will be kept at the school and providing the school with the back-up medication.

• informing school staff in writing of any changes in the student's treatment or asthma management.

• informing the school of any asthma exacerbations, hospital visits, and/or new or changed student medical information. • informing school staff in writing of any medication side effects that warrant communication to the parent/guardian

• coordinating distribution of the student's asthma management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff).

I understand and agree to the conditions of the school policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above-named student. I release the school and its employees and agents of any legal responsibility related to the above-named student's possession and self-administration of his/ her asthma medication.

_____ _____

Parent/Legal Guardian Signature Date

I, _____, (student's name) have been instructed in the proper use of my prescription asthma medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

_____ _____

Student's Signature Date

The above-named student has been instructed and demonstrates understanding of the proper use of his/her asthma medication. It is my professional opinion that the student be permitted to carry and self-administer his/her asthma medication. I have provided the parent/guardian with a written asthma emergency/management plan including the name, purpose, dosage, and administration directions of the asthma medication.

_____ _____

Healthcare Provider Signature Date

Student Name: _____ Date of Birth _____
Parent Name(s): _____
Healthcare Provider: _____

2. Authorization To Give Medication at School

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page.

I request that Achieve Academy ("the school"), through the principal or designee, supervise/assist in the administering of mediation to my child according to instructions the instructions below. I understand that:

Medications must be in the original labeled container (no baggies foil, etc.) Pharmacies can provide a duplicate labeled container with only the school doses.

Parent/guardian must provide special instructions, as well as the medication and related equipment to the principal.

It will be the responsibility of the parent/guardian to inform the school of any changes. New medications or new doses will not be given unless a new form is completed and a newly labeled container is provided.

All medications will be taken directly to the office/clinic by the parent/guardian.

Unused medication will be disposed of unless picked up within one week after medication is discontinued.

Name of medication: _____

Dose: _____ Route (by mouth, topical, etc.): _____ Time(s) to be given: _____

Stop medication on: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the school personnel, employees and officials of the Achieve Academy to assist my child in taking prescribed medication according to school policy and I release them form any liability for administering this medications I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_____ _____

Parent/Legal Guardian Date

Home Phone _____ Work Phone _____ Cell Phone _____

To be completed by healthcare provider

Condition/Illness Requiring Medication: _____

Possible Side Effects if any:_____

_____ _____

Printed Name of Healthcare Provider Phone Number

_____ _____

Signature of Healthcare Provider Date