MEDICATION /PROCEDURES/TREATMENTS

Please list **ALL** medications your child receives at home.

Med/Treatment	Dose	Time	Reason	Side Effects

_____

_____

HEALTH CARE ACTION PLAN

Please list all medication, interventions or procedures your child needs while at school. Medications/Procedures are to be administered by Nursing staff or other trained staff.

Only when your child has a medical need for which medication or treatment is required during the school day will Benton County Sunshine School allow for medication/treatment. An MD prescription is required for medical treatment at school.

I hereby request that the following medication(s) be given to my child _____ in the specific dosage (s) and at the indicated time (s) as stated below. A pharmacy container is required for all prescriptions. The pharmacy container dosage instructions must match the current label and dosage instructions given below.

Med/Treatment	Dose	Route	Time	Storage

I indemnify and hold harmless Benton County Sunshine School Inc., its employees or agent from any and all liabilities of any kind or nature arising from injury or damage to my child as related to the administration of the above medication or treatment as indicated.

Parent Signature_____Date_____

ECSE _____ Date_____

RN Signature_____Date_____

Student Name: _____DOB:_____

EMERGENCY PLAN-

If you see this:	Do this:

PARENT/PHYSICIAN AUTHORIZATION FOR HEALTH SERVICES AT BENTON COUNTY SUNSHINE SCHOOL

I, _____request and approve of the Individualized Care Plan. I understand that a qualified and trained person (s) will be performing the school health services (s). I will notify the school immediately if the health status of _____ changes, I (we) change physicians, or there is a change or cancellation of the procedure. I agree to provide the following, if any: equipment, supplies, medication (in labeled prescription bottle/container), dietary supplements and help in training:

_____

_____

_____ _____

Signature of Parent/Guardian Date

_____

As the physician for _____ (student name), I verify that it is necessary to perform the procedures and treatments, as described, during the school day.

_____ I have reviewed the Individualized Health Care Plan and approve of it as written.

_____ I approve the Individualized Health Care Plan with the following modifications:
_____

_____ I do not approve the Individualized Health Care Plan. I have attached a Substitute plan:
_____

_____ _____

Physician's Signature Date