Department of School Health Services

Prescription Medication/Treatment Request

In accordance with Section 22.052 of the Texas Education Code, The Burkburnett Independent School District (BISD) has established the following rules concerning the administration of medication or treatment to students by school district employees.

1. Treatment or prescribed medication will be administered during school hours only when ordered by the physician.
2. The information requested below must be complete. Both the parent/guardian and physician requesting the treatment and/or medication must sign this form. A separate form must be completed and submitted for each requested treatment or medication.
3. PARENT/GUARDIAN must personally deliver the identified medication/treatment supplies to the School Nurse, along with this completed and signed form.
4. Prescription medications must be labeled with name of the student, the date of the prescription's issue, the name and quantity of medication, and directions for its use. (You may ask your pharmacist for a second, properly labeled bottle so you have one for home and one for school).
5. If applicable, the procedures must meet the IEP requirements of a student with disabilities. Special equipment will be provided in accordance with the IEP.
6. The School Nurse RN may contact the physician for order clarification and the physician may disclose any information concerning that student to the School Nurse or other representative of BISD.
7. The only persons authorized to administer medications/treatments are persons designated by the BISD Health Care Coordinator or campus principal and those who have competency verification by the supervising RN.
8. ADDITIONAL ORDERS FOR INHALERS AND NEBULIZERS ARE ON THE BACK OF THIS FORM.
9. Please complete the following (please print):

Name of Student:		Birth date:
Address:		School:
Home Phone:	Emergency Phone:	Grade:
Medication Allergies:		Food/Environmental Allergies:
Prescribed Medication/Treatment:		Dosage:
		Time(s) of Administration:
Diagnosis:		Route of Administration:
Date of Request:		Termination Date of Medication/Treatment:
Precautions/Unfavorable Reactions: Interactions Related to Medication/Treatment:		
Physician Ordering Medication/Treatment:		Physician Phone Number(s):
Physician's Office Address:		Physician Office Fax Number:

Physician's Signature:_____

PARENTS TO COMPLETE THIS SECTION	
I, the undersigned legal parent/guardian of the above named student request the medication or procedure described above be administered to my child during school hours. I fully understand that trained NON-MEDICAL personnel may administer the medication, procedure or treatment to my child.	
Parent/Guardian Signature: Relationship:	Telephone Numbers: Home: _____ Work (Mother)_____ (Father)_____

Revised 8/1/05

Student Name:_____

ADDITIONAL ORDERS FOR INHALERS AND NEBULIZERS:

<table>
<tr><th>IF SPECIFIED MEDICATION IS AN INHALER, PLEASE ADDRESS THE FOLLOWING:</th><th>IF SPECIFIED MEDICATION IS TO BE ADMINISTERED BY NEBULIZER, PLEASE ADDRESS THE FOLLOWING:</th></tr>
<tr><td>Inhalers are kept locked in the Nurse's Office to facilitate their accessibility and monitoring of student's condition.

(a) May this student carry an inhaler on himself/herself during the day?

☐ YES ☐ NO</td><td>(a) Is the student permitted to keep his/her nebulizer in the nurse's office?

☐ YES ☐ NO</td></tr>
<tr><td>(b) Has the student been instructed on the use of inhalers?

☐ YES ☐ NO</td><td>(b) Has the student been instructed on the use of the nebulizer?

☐ YES ☐ NO</td></tr>
<tr><td>(c) Is the student able to self-administer the inhaler?

☐ YES ☐ NO</td><td>c) Is the student able to prepare and self-administer his/her nebulizer treatments?

☐ YES ☐ NO</td></tr>
<tr><td>(d) Has the student been instructed in Peak-Flow monitoring?

☐ YES ☐ NO</td><td rowspan="3">(d) Please describe below the care and maintenance of the Nebulizer used at School, or supply nurse personnel with a copy of the instructions furnished with the nebulizer from the manufacturer. Ensure that the instructions have the student's name clearly noted on them.

(e) Students are to clean their nebulizers after each use in the clinic. Cleaning materials will need to be provided for each student</td></tr>
<tr><td>(e) Do you want the student to monitor his/her Peak-Flow levels at school?

☐ YES ☐ NO</td></tr>
<tr><td>(f) At what level should this student be considered within his/her normal range?

Range:</td></tr>
</table>