# Medication and Medical Procedure Treatment Plan

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

WE ARE WASHINGTON DC — GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

**Use this form to** detail your student's medication and/or medical procedure plan to be administered at their school and return it to the Health Suite Personnel. The Health Suite Personnel will contact you to arrange medication/medical supply drop-off. For multiple needs, complete multiple sheets.

## Part 1: Student and Parent/Caretaker Information | To be completed by student's parent/caretaker.

| | | |
|---|---|---|
| **Student First Name:** | **Student Last Name:** | **Grade:** |
| **School Facility Name:** | | **Student DOB:** |
| **Parent First Name:** | **Parent Last Name:** | |
| **Parent Email:** | | **Parent Phone:** |

I hereby request and authorize Health Suite Personnel to administer prescribed medication/treatment as directed by the licensed health care providers to the student named in Part I. I understand that:

- I am responsible for bringing the necessary medications/medical supplies to school for the Health Suite Personnel.
- All medication/medical supplies will be stored in a secured area of the school. Health Suite Personnel will not assume any responsibility for possible loss of student medication/medical supplies.
- Within one week of the expiration of the medication/medical supplies and/or within one week of the end of the school year, I must collect what is unused or it will be destroyed.
- The School or Health Suite Personnel will not assume any responsibility for unauthorized medication/treatments that the student gives to himself/herself.
- If any changes occur in my student's health or treatment plan, I will immediately notify the school and health suite personnel annually as required by DC Official Code § 38-651.03.
- Treatment plans and medication plans must be updated annually and when there is any change in the student's health or treatment requirements.
- I hereby acknowledge that the District, and its schools, employees, and agents shall be immune from civil liability for acts of omissions under DC Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

**Parent/Caretaker Signature:** ______________________________ **Date:** ______________

## Part 2a: Student's Medication Plan | To be completed by licensed health care provider.

**Diagnosis:** | **End date for school administration of this medication:**

**This medication is:** ☐ New; the first dose was given at home on date and time: ______________ ☐ Renewal ☐ Change

**Is this a standing order?**
- ☐ Yes, epinephrine auto injector 0.15 mg: *refer to anaphylaxis plan*
- ☐ Yes, epinephrine auto injector 0.3 mg: *refer to anaphylaxis plan*
- ☐ Yes, albuterol sulfate 90 mcg/inh: *refer to asthma action plan*
- ☐ Yes, other: ____________________
- ☐ No

**Name and strength of medication:** | **Dose/route:**

**Time and Frequency at School** *(e.g. 10am and 2pm every day; as needed if standing order)*

**If a reaction can be expected, please describe:**

**Additional instructions or emergency procedures:**

## Part 2b: Student's Medical Procedure Treatment Plan | To be completed by licensed health care provider.

**Diagnosis:** | **This procedure is:** ☐ New ☐ Renewal ☐ Change

**Treatment:**

**When should treatment be administered at school?** *(e.g. 10am and 2pm every day)*

**End date for school administration of this treatment:**

**Additional instructions or emergency procedures:**

Has the student's Universal Health Certificate form been updated to reflect new health concerns? ☐ Yes ☐ No

| **Licensed Health Care Provider Office Stamp** | |
|---|---|
| | **Provider Name:** |
| | **Provider Phone:** |
| | **Provider Signature:** **Date:** |

## OFFICE USE ONLY | Medication and/or treatment plan received by Health Suite Personnel.

**Name:** **Signature:** **Date:**