REQUEST FOR NURSE DIRECTED MEDICATION ADMINISTRATION

Requests to administer nurse directed medication during school hours requires that this statement be filed with the school principal. Consideration of this request will be based on school health guidelines. Please respond to every item on this form. Only totally completed forms will be honored.

School _____ **School Hours** _____ **Teacher** _____ **Grade** ____

Student Name _____ **Date of Birth** _____ / _____ / _____
Last First Middle

Address _____ **Telephone** _____

Medical Conditions (Optional) _____ **Cell Phone** _____

HEALTH CARE PROVIDER STATEMENT

The health care provider may be a medical doctor (MD, DO), dentist (DDS), physician assistant (PA), or an advanced nurse practitioner (APRN/NP).
To be completed by health care provider. A new form is required each school year.

Name of Drug / Purpose of Drug : _____

Date to Start: _____ **through** _____

Dosage, Route and Times at School _____

Does this medication absolutely need to be administered during school hours? _____**Yes** _____**No** **If yes, explain:** _____

_____

If the dose of this medication is different from the manufacturer's recommended dose range for the age or weight please include your rationale for prescribing outside of these recommendations:

_____

_____

_____

_____

Special instructions for storage and handling: _____

Possible side effects: _____

Health Care Provider Name: _____ **Phone:** _____

Address: _____

Health Care Provider Signature: _____ **Date:** _____
(For prescription medications)

Pursuant to HIPAA regulations, 45 C.F.R. §164.506 and § 1654.501, I may disclose protected health information regarding this student's treatment activities to be implemented by Metro Nashville Public School and the school nurse program.

To Be Completed by Parent / Guardian

I understand I am requesting a Nurse Directed Medication Administration be performed for my child. I understand a qualified individual will administer such medication. I understand that all medications provided to the school for use must be labeled by the pharmacist and in the original container. Changes during the year require a signed authorization from the health care provider. I understand that to properly perform this medication administration, the school nurse program may require clarification from the health care provider to assist them in the treatment activities that I have requested. I understand that the health care provider may disclose protected health information in consultation with the school nurse.

Parent/Guardian Signature: _____ **Date:** _____

Phone Number (in case of emergency): __(_____)_____