



**Instructions for the School Medication Prescriber/Parent Authorization Form (PPA) & Management Plan, (IHP) Individualized Healthcare Plan, (EAP) Emergency Action Plan, and (CAP) Classroom Action Plan for OTHER MEDICAL CONDITION**

**1. (IHP) Individualized Healthcare Plan/(EAP) Emergency Action Plan/(CAP) Classroom Action Plan**

- Section I – Parent/Guardian must complete.
- Section II – Physician, Physician’s Assistant, or Nurse Practitioner must complete.
- Signatures - Parent/Guardian, Physician, Physician’s Assistant, and/or Nurse Practitioner must sign and date.

*\*Alabama Board of Nursing requires the following to be completed on all (PPAs) for each Med/Dose*

**2. School Medication Prescriber/Parent Authorization Form (PPA)**

- **Prescriber Authorization Section: (Prescription & Over-the-Counter Medications)**
  - **Every blank must be completed** to include: med, dosage, time, route, start and stop dates, reason, special instructions, sign and date,
  - Med(s) will not be accepted or administrated with an incomplete and/or incorrect PPA,
  - Complete one PPA for each med & each dose,
  - Start Date and Stop Date - Please list specific dates,
  - Use as Directed instructions will not be accepted - must be specific,
  - Frequency/Time(s) to be given – “as needed”, please include time parameters (example: every 4 hours as needed), and
  - Self-Administer/Self-Carry - Only med(s) to prevent &/or treat medical emergencies are acceptable.
- **Parent/Guardian Section**
  - **Student Information Section-** Parent/Guardian must complete every question including: allergies, weight and birth date,
  - **Parent Authorization Section-** Parent/Guardian must sign and date, and
  - **Self-Administration Authorization Section-** Parent/Guardian must sign and date to allow student to self-medicate and/or self-carry approved med at school.

Parent/Guardian must bring in PPA(s), medication(s), and management plan(s) directly to the school nurse or designated medication assistant. Students, unless prescribed to ‘Self-Administer/Self-Carry’, may not bring in their own medication(s). All medications (to include over-the-counter & prescription) must be counted and logged-in each time.

**Expired Medication(s):** Please be aware of medication expiration dates. You will be notified when your child’s med expires.

**End of School Year:** All medication(s) must be signed out at the end of the school year. Medication(s) left in the clinic after that time will be discarded according to federal and state guidelines.

Sincerely,

School Nurse

If you have received this packet in error, or if your student’s medical condition does not require emergency planning, please sign below and return this form to your child’s teacher or school nurse.

- Received in error       Student’s medical condition does not require medication and/or emergency planning

Student Name: \_\_\_\_\_

Comments: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HCS School: \_\_\_\_\_ School Year: \_\_\_\_\_ School Hours: \_\_\_\_\_  
 Stop Date: \_\_\_\_\_ Extracurricular Hours: \_\_\_\_\_

**MANAGEMENT PLAN FOR OTHER MEDICAL CONDITION WITH MEDICATION AT SCHOOL**

Individualized Healthcare Plan (IHP) / Emergency Action Plan (EAP) / Classroom Plan (CAP) / Extracurricular Plan / Bus Plan

**FOR THE FOLLOWING MEDICAL CONDITION:** \_\_\_\_\_

**SECTION I – Parent (Please Print):**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_

Known Allergies/Triggers: \_\_\_\_\_ Wt. \_\_\_\_\_

Medications Taken at Home: \_\_\_\_\_

Bus Transportation to and from school: Bus # a.m. \_\_\_\_\_ Bus # p.m. \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Cell # Home # Work #

Emergency Contact: \_\_\_\_\_  
Name Cell # Home # Work #

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Preferred Hospital in Case of Emergency: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Policy/Group # \_\_\_\_\_  
(optional) (optional)

**SECTION II – Physician: (Please Print)**

**SCHOOL PLAN:**

IF YOU SEE THIS...	DO THIS...

ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION (PPA) SIGNED BY THE PRESCRIBER  
 FIELD TRIPS: Emergency medications *should NOT be left* in a backpack on the bus or with a teacher who is not with the student.  
 BUS PLAN: Follow Emergency Plan, Pull Over, Call 911, and Call Parent/Guardian or Emergency contact  
 Only self-carry/self-administer medications will be available.  
 EXTRACURRICULAR PLAN: Medication Assistant/Sponsor will follow Management Plan and PPA.

**I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:**

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency and for the release of my child's medical information to be shared with appropriate persons on an as-needed basis to insure the health and safety of my child. A nurse will not be present on the school bus, private car, or extracurricular activity.

\_\_\_\_\_  
Physician Signature Date Parent Signature Date Student Signature Date Nurse Signature Date

**FOR SCHOOL NURSE USE ONLY**

Medication	Self Carry?	Self Administer?	Expiration	Location of Medication

HCS School: \_\_\_\_\_ School Year: \_\_\_\_\_ School Hours: \_\_\_\_\_  
 Stop Date: \_\_\_\_\_ Extracurricular Hours: \_\_\_\_\_

**MANAGEMENT PLAN For OTHER MEDICAL CONDITION WITHOUT MEDICATION AT SCHOOL**  
*Individualized Healthcare Plan (IHP) / Emergency Action Plan (EAP) / Classroom Plan (CAP) / Extracurricular Plan / Bus Plan*

FOR THE FOLLOWING MEDICAL CONDITION: \_\_\_\_\_

**SECTION I – Parent (Please Print):**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_

Known Allergies/Triggers: \_\_\_\_\_ Wt. \_\_\_\_\_

Medications Taken at Home: \_\_\_\_\_

Bus Transportation to and from school: Bus # a.m. \_\_\_\_\_ Bus # p.m. \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Cell # Home # Work #

Emergency Contact: \_\_\_\_\_  
Name Cell # Home # Work #

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Preferred Hospital in Case of Emergency: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Policy/Group # \_\_\_\_\_  
(optional) (optional)

**SECTION II – Parent (Please Print):**

**School Plan:**

IF YOU SEE THIS...	DO THIS...

\* ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION (PPA) SIGNED BY THE PRESCRIBER  
 FIELD TRIPS: Supplies ***should NOT be left*** in a backpack on the bus or with a teacher who is not with the student.  
 BUS PLAN: **Follow Emergency Plan, Pull Over, Call 911, and Call Parent/Guardian or Emergency contact**  
 EXTRACURRICULAR PLAN: **Medication Assistant/Sponsor will follow Management Plan and PPA.**

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\_\_\_\_\_  
 Physician Signature Date Parent Signature Date Student Signature Date Nurse Signature Date

HCS School: \_\_\_\_\_ School Year: \_\_\_\_\_ School Hours: \_\_\_\_\_  
 Stop Date: \_\_\_\_\_ Extracurricular Hours: \_\_\_\_\_

**MANAGEMENT PLAN For OTHER MEDICAL CONDITION WITHOUT MEDICATION AT SCHOOL**  
*Individualized Healthcare Plan (IHP) / Emergency Action Plan (EAP) / Classroom Plan (CAP) / Extracurricular Plan / Bus Plan*

FOR THE FOLLOWING MEDICAL CONDITION: \_\_\_\_\_

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Medications Taken at Home: \_\_\_\_\_

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Name Cell # Home # Work #

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Name Cell # Home # Work #

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Preferred Hospital in Case of Emergency: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Policy/Group # \_\_\_\_\_  
(optional) (optional)

**SECTION II – Parent (Please Print):**

**School Plan:**

IF YOU SEE THIS...	DO THIS...

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I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency and for the release of my child's medical information to be shared with appropriate persons on an as-needed basis to insure the health and safety of my child. A nurse will not be present on the school bus, private car, or extracurricular activity.

\_\_\_\_\_  
 Physician Signature      Date      Parent Signature      Date      Student Signature      Date      Nurse Signature      Date

**SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION**

School Year: \_\_\_\_\_ - \_\_\_\_\_

**STUDENT INFORMATION**

Student's Name: \_\_\_\_\_ School: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
 No known drug allergies---if drug allergies list: \_\_\_\_\_ Weight: \_\_\_\_\_ pounds

**PRESCRIBER AUTHORIZATION** (To be completed by licensed healthcare provider)

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_  
 Frequency/Time(s) to be given: \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Stop Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for taking medication: \_\_\_\_\_  
 Potential side effects/contraindications/adverse reactions: \_\_\_\_\_  
 Treatment order in the event of an adverse reaction: \_\_\_\_\_

**SPECIAL INSTRUCTIONS:**

Is the medication a controlled substance? Yes  No   
 Is self-medication permitted and recommended? Yes  No   
 If "yes" I hereby affirm this student has been instructed  
 On proper self-administration of the prescribe medication.  
 Do you recommend this medication be kept "on person" by student? Yes  No

Printed Name of Licensed Healthcare Provider: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax: \_\_\_\_\_ - \_\_\_\_\_  
 Signature of Licensed Healthcare Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT AUTHORIZATION**

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

**Prescription Medication** must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

**Over the Counter Medication** must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**SELF-ADMINISTRATION AUTHORIZATION**

**(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)**

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_