See the following pages regarding administering medication and emergency health care to students:

Exhibit A: Request for Administration of Medication — 2 pages

Exhibit B: Request for Athletic Trainer to Administer Medication — 2 pages

Exhibit C: Guidelines for Physical Examination of a Student — 1 page

Exhibit D: Self-Administration of Prescription Asthma Medication — 3 pages

EXHIBIT A

SPRING INDEPENDENT SCHOOL DISTRICT
REQUEST FOR ADMINISTRATION OF MEDICATION

This form must accompany each medication to be administered, whether prescription or non-prescription medication. Additional copies of this form are available in the nurse's office or copies may be made of this sheet.

To: Principal, ____ (school name)

Date: _____________________________

As parent/guardian of _____________________________, a student in the _____ grade, I (print parent's name) _____________________________, give permission for Spring Independent School District to administer to my child, the following medication:

Name of medication: ____

Color: ____________________ Dose (amount) to be administered: ___________________

Time to be administered: ______________________________

Date to discontinue: __________________________________

Additional instructions or side effects regarding the above medication:

____

Reason for administering medication: ____

Student's physician name: ____

Telephone Number: (____)___________________

Prescription medication must be in the original container with the student's name, the doctor's name, and a current date. It will be given according to the instructions on the label. Non-prescription medication must be in the original container and will be given according to directions.

Medication for students in elementary schools must be brought to the school by the parent. Medication may not be transported by elementary students on the bus.

School clinic staff is authorized to contact and consult with your child's physician regarding the child's medical needs.

The District, the Board, and the staff shall be immune from civil liability for damages or injuries resulting from the administration of medication to a student.

Parent/Guardian Signature ____

Work Phone: (____)______________________ Home Phone: (____)____________________

Physician's Signature (if required*) ____

Date ________________________________

* Required annually in treatment of long-term medication administration as in asthma, diabetes, chronic infections, Attention Deficit Disorder, controlled medicines, and over-the-counter medicines given daily for more than two weeks.

EXHIBIT B

SPRING INDEPENDENT SCHOOL DISTRICT
REQUEST FOR ATHLETIC TRAINER TO ADMINISTER MEDICATION

To: Principal, _______________________________ (school name)

Date: __________________________

I, ________________________________ (name), am the parent/guardian of _______________________________ (student's name), a student in the (grade) _____ level. I request that an athletic trainer employed by the Spring Independent School District give my child the following medication(s) as needed:

NONPRESCRIPTION MEDICATIONS

Check the nonprescription medication(s) below that you request to be administered to your child by the athletic trainer on an "as needed" basis:

	Tylenol		Aleve
	Advil		Pepto-Bismol
	Advil Cold and Sinus		Robitussin Cough Formula
	Cepacol Throat Lozenges		Hydrocortizone Cream
	Chloraseptic Spray		Triple Antibiotic Ointment
	Oral Gel		Other (Specify, i.e., Blistex, etc.)
	Antacid		

PRESCRIPTION MEDICATION

I request that the following, ____________________________________ (name of prescription medicine), be administered to my child, _______________________________, when prescribed by a physician.

Prescription medication must be in the original container with the student's name, the doctor's name, and a current date. It will be given according to the instructions on the label.

Name of prescription medication: ____

Color: ___________________ Dose (amount) to be administered: _______________________

Time(s) to be administered: ____

Additional instruction or side effects regarding any of the above medication(s):

____

Student's Personal Physician's Name ____

Telephone Number ____

The District, the Board, and the staff shall be immune from civil liability for damages or injuries resulting from the administration of medication to a student.

I give permission for my child, ________________________________ (Student's Name), to receive medication as instructed on this form.

Parent/Guardian Signature ____

Work Phone: (___)______________________ Home Phone: (___)______________________

Date ___________________________

EXHIBIT C

SPRING INDEPENDENT SCHOOL DISTRICT
GUIDELINES FOR PHYSICAL EXAMINATION OF STUDENT

The guidelines are:

1. Nurses, health aides, and other appropriate school personnel may perform only those physical examinations necessary to respond to immediate health needs.
2. A nurse, health aide, or other appropriate school personnel may determine that it is necessary to roll up a shirt sleeve or pant leg, remove a jacket or shirt, or loosen or remove pants in order to adequately examine the student.
3. Except as otherwise provided in this guideline, undergarments may be removed from a student only if a nurse, health aide, or other school personnel determines a medical necessity exists, including suspected abuse. When such a determination is made, undergarments may be removed from a student only if another adult of the same gender as the student is present.
4. In an emergency situation, school personnel may remove a student's undergarments without the presence of another adult of the same gender as the student if immediate action regarding the student's health is required.
5. School personnel may remove a student's undergarments without the presence of another adult of the same gender if the school personnel is changing diapers, assisting with toileting, or cleaning a child after a toileting accident.

EXHIBIT D

SPRING INDEPENDENT SCHOOL DISTRICT
Distrito Escolar Independiente de Spring

16717 ELLA BOULEVARD * HOUSTON, TEXAS 77090 (281) 586-1100

FORM FOR SELF-ADMINISTRATION OF PRESCRIPTION ASTHMA MEDICATION
Forma De Auto-Administración De Medicina Formulada Para El Asma

Student name (*Nombre del estudiante*) ____________________

In grade (*En grado*) ____________ has asthma and is capable of self-medication. (*tiene asma y es capacitado para administrarse la medicina*.)

Physician signature (*Firma del doctor*) ____________________

Phone number (*Teléfono*) ____________________

Name of medication (*Nombre de la medicina*) ____________________

Dosage (*Dosis*) ____________________

Time of administration (*Horas para aplicarta*) ____________________

Date to discontinue (*Fecha para descontinuaría*) ____________________

Purpose for administering medication (Propósito de la aplicación de la medicina)

____

Medication must be dispensed following the Spring Independent School District's medication policy. This form must be completed in addition to the routine District medication authorization form. (*La medicina debe administrarse siguiendo las reglas del Distrito Escolar Independiente de Spring. Está forma se debe completar en adición con la forma rutinaria del distrito para la autorización de los medicamentos.*)

Responsibility For Carrying Prescription Asthma Medication (*Responsabilidades Para Llevar Medicina Formulada Para El Asma*):

Yes/*Si*	No	
☐	☐	Asthma Care Plan Returned (*Regreso la forma del Plan de cuidados para del Asma*)
☐	☐	Correct use of prescription asthma medication use observed by nurse. (*Uso correcto del medicina formulada para Asma observado por la enfermera.*)
☐	☐	Proper timing for prescription asthma medication use observed by nurse. (*Tiempo apropiado con el uso del la formulada medicina para Asma observado por la enfermera.*)

Yes/*Si*	No	
☐	☐	Not sharing prescription asthma medication with other students. (*No compartir la Formulada Medicina para Asma con otros estudiantes.*)
☐	☐	Keep prescription asthma medication in student's belongings. (*Mantener la Formulada Medicina para Asma con las pertenencias del estudiante.*)
☐	☐	Provides a second prescription asthma medication to be kept in the health clinic. (*Proveer un segundo Formulada Medicina para Asma y mantenerlo en la Clínica de Salud.*)
☐	☐	Properly labeled prescription on immediate prescription asthma medication. If the container is too small for a full label, it must be labeled with student name and prescription number with the full label on the outer box or container. (*Apropiada etiqueta con la medicina, es decir, la formulada medicina para Asma. Si el envase es muy pequeño para la escritura en la etiqueta completa, entonces debe estar marcada con el nombre del estudiante y el número de la receta y la etiqueta completa por fuera de la caja de la medicina.*)
☐	☐	Agrees to come directly to the health clinic if the student continues to have difficulty with breathing, wheezing, or is experiencing chest tightness after using the prescription asthma medication. (*El estudiante está de acuerdo de ir directa-mente a la clínica si tiene constante dificulta de respirar, resollar, o si esperimenta apretamiento de pecho después de haber usado la formulada medicina para Asma.*)

The student [does] [does not] demonstrate meeting the above specified responsibilities. The privilege of carrying the prescription asthma medication [will] [will not] be allowed.

El estudiante [si] [no] demuestra que cumple las responsabilidades especificadas en la parte de arriba. El privilegio de llevar la formulada medicina para asma [se le permite] [no se le permite].

Student Signature (*Firma del Estudiante[a]*): ______________________________

Date (*Fecha*): ______________________

RN Signature (*Firma de Enfermero[a] Registrada*): __________________________

Date (*Fecha*): ______________________

Principal Signature (*Firma del Principal*): ______________________________

Date (*Fecha*): ______________________

My child will be responsible for carrying this prescription asthma medication and will self-administer. My child agrees to follow the District's procedures concerning the handling and administration of this medication. I understand that school personnel are unable to monitor the frequency or method or usage of prescription asthma medication when it is carried by the student.

Será la responsabilidad de mi hijo(a) para llevar la formulada medicina para asma y administrársela. Mi hijo(a) está de acuerdo en seguir los procedimientos del distrito referentes a la dirección y administración de este medicina. Entiendo que el personal de la escuela es incapaz de controlar la frecuencia o el método o uso de la formulada medicina para asma cuando el estudiante la tiene.

Parent/Guardian Signature (*Firma de los Padres/Guardián*): ___________________________

Date (*Fecha*): ______________________________