THE GLADYS H. OBERLE SCHOOL

404 Willis Street
Fredericksburg, VA 22401
(540) 372-6710
(540) 373-1791 FAX
(888) 371-0597 toll free

2021-2022

REQUEST FOR MEDICATION/TREATMENT DURING SCHOOL HOURS

THIS APPLIES TO ANY MEDICAL PRESCRIPTION

Employment Resources Incorporated (ERI) requires that if medication/treatments are to be taken by a student during the school day, the school **MUST** have the following information completed and on file. In addition, this information **MUST** be updated as soon as changes occur:

TO BE COMPLETED BY THE PHYSICIAN: (Please print)

Student's Full name:

Medication/Treatment:

Dosage and Time Schedule:

Diagnosis:

Length of Time Medication/Treatment Required:

Precautions, Special Instructions, Possible Side Effects, Comments:

Name of Prescriber:

Signature of Prescriber:

Address:

Telephone: Date:

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that school personnel administer the above medication/treatment ordered by the physician as stated and according to the directions given. I authorize a representative of the school to share information regarding this medication/treatment with a health care provider in an emergency. I understand and agree to comply with the school's policies and procedures.

Signature of Parent/Guardian Date

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REQUEST FOR OVER-THE-COUNTER MEDICATION/TREATMENT MEDICAL STANDING ORDERS

THIS APPLIES TO ANY OVER-THE-COUNTER MEDICATION

Employment Resources Incorporated (ERI) **MUST** have the following information completed and on file if medication/treatments are to be taken by a student during the school day. In addition, this information **MUST** be updated as soon as changes occur:

I, _____ , authorize

Doctor's Name _____ Patient's Name

to receive the following over the counter medications administered according to the indications and instructions of that medication's label.

Check all that apply:

- ☐ Acetaminophen
- ☐ Antacid tablets
- ☐ Antibiotic cream/ointment
- ☐ Calamine (anti-itch topical)
- ☐ Cough syrup
- ☐ Hydrocortisone Cream (1%)
- ☐ Ibuprofen
- ☐ Menthol drops
- ☐ Midol
- ☐ Other:
- ☐ Other:

To my knowledge the patient has the following medication allergies:

Parent/Guardian Signature: _____ Date: _____

Prescriber Signature: _____ Date: _____

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ASTHMA AWARENESS INFORMATION

Student's Name: Date of Birth:

Parent(s)/Guardian(s) Name: Phone:

Current Asthma Medication(s):

Known Asthma Triggers: (Click all that apply)

- ☐ Colds
- ☐ Dust
- ☐ Excitement
- ☐ Food (Specify):
- ☐ Mold
- ☐ Strong Odors
- ☐ Weather Changes
- ☐ Exercise
- ☐ Grass
- ☐ Animals
- ☐ Other (Specify):
- ☐ Tree Pollens
- ☐ Flowers
- ☐ Smoke

Typical Signs and Symptoms of an asthmatic episode: (Click all that apply)

- ☐ Fatigue
- ☐ Flaring nostrils
- ☐ Difficulty playing
- ☐ Difficulty talking
- ☐ Agitation
- ☐ Grunting
- ☐ Other(s):
- ☐ Rapid Respirations
- ☐ Persistent coughing
- ☐ Difficulty eating
- ☐ Face red, pale or swollen
- ☐ Mouth open (panting)
- ☐ Restlessness
- ☐ Dark circles under the eyes
- ☐ Gray or blue lips or fingernails
- ☐ Difficulty drinking
- ☐ Wheezing
- ☐ Sucking in chest/neck
- ☐ Complains of chest pain

Parent/Guardian Signature: Date: