RISE Learning Center

5391 Shelby Street, Indianapolis, IN 46227 Phone (317) 789-1621 Fax (317)780-4268

MEDICAL INFORMATION FORM

***Please complete this form and enclose any relevant information*.** **School Year: 2024-2025**

Student:_____ DOB:_____ Age:_____ Grade: ____ Teacher:_____

Parents/Guardians names: _____

Medical Diagnosis: _____

Physical Restrictions or special equipment (Wheelchair, Baclofen pump, Oxygen, Urinary Catheter):
Other: _____

List any of the following diagnosis for your student:

- ☐ **Allergies (Life Threatening)****
  - ☐ Bees/insects/Latex (circle)
  - ☐ Foods_____
  - ☐ Medication _____
  - ☐ Other_____
- ☐ **Asthma**
- ☐ **Autism**
- ☐ **Bleeding Disorder _____**
- ☐ **Bone/Joint/Muscular Disorder**
- ☐ **C. diff, MRSA, CMV (circle)**
- ☐ **Cancer**
- ☐ **Cerebral Palsy**
- ☐ **Diabetes/Endocrine _____**
- ☐ **Emotional/Behavior Disorder**
- ☐ **Feeding Disorder/Feeding Dysfunction**
- ☐ **G-tube/GJ tube**
- ☐ **Hearing or Vision Loss**
- ☐ **Heart Condition/ High Blood Pressure**
- ☐ **Hydrocephalus/ VP Shunt Side: _____**
- ☐ **Kidney Disease**
- ☐ **Monte/Mace _____Cath MD order**
- ☐ **PICC Line**
- ☐ **Seizures or Epilepsy:**
  Last seizure date _____
- ☐ **VNS _____**
- ☐ **Tracheostomy _____MD order**
- ☐ **Requires suctioning _____MD order**
- ☐ **Other: _____**

PLEASE LIST ALL ALLERGIES AND REACTIONS: _____
_____

GENERAL INFORMATION:

- **It is the Parent/Guardian responsibility to notify RISE Learning Center of any changes to this plan during the school year.**
- **School personnel will contact 911 for emergency service, if condition warrants.**
- **Any medical costs incurred are at the expense of the family.**
- If your child is injured and requires first aid, the injury will be cleaned with soap and water, antiseptic solution or hydrogen peroxide. A warm/cool compress and a Band-Aid/bandage may be applied. Sunscreen may be applied for outdoor activities.

PRESCRIPTION AND EMERGENCY MEDICATIONS: If your student has a serious health condition or a life-threatening allergy that requires the use of any emergency medication, please contact the nurse at 789-1641. Doctor's orders are necessary for the use of all emergency medication including but not limited to: Epi-Pen, Albuterol (Inhaler, Nebulizer), Glucagon, BAQSIMI®, Diastat or Midazolam. Please see the reverse side of this form for guidelines regarding ALL prescription medications, including emergency meds. All medications must be delivered by a parent/guardian to the school clinic- medications may **NOT** be transported on the bus.

OVER-THE-COUNTER (OTC) MEDICATIONS: *By signing below*, you are consenting to your child receiving over-the-counter (OTC) medications as needed. OTC medications will **NOT** be administered without the parent/guardian signing and dating below. The clinic stocks the following OTC meds: acetaminophen (Tylenol), ibuprofen (Advil/Motrin), diphenhydramine (Benadryl), Pepto Bismol, Tums, anti-itch cream (Benadryl cream and aloe vera), antibiotic ointment (Neosporin), and cough drops.

- **My student may receive an age appropriate dose of over-the-counter medication at school as needed.**
- **I understand that medications, both prescription & over the counter, cannot be brought or sent home with my student. I must personally deliver & pick up the medication(s) to and from school. Prescription medications must have a current prescription label and will be counted together with school personnel.**

Parent/Guardian Signature: _____ Date: _____

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The **RISE Learning Center** discourages the administration of daily prescription medication during school hours and requests, whenever possible, the medication be scheduled other than during school hours. Recognizing that this is not always possible, school personnel will cooperate in administering medication(s) that must be given during school hours.

Our school procedures (including medication administration) require:

1. A Doctor's written orders detailing the medication name, dosage, route, and time medication is to be given. This form must be signed and dated by the doctor.
2. Using this form, the signature of the parent or guardian requesting the school comply with the physician's order.
3. Medication must be brought to school by the parent or guardian in a container appropriately labeled by the pharmacy with the correct time/current dosage. Prescription medications will be counted together with school personnel.

Physician's Name: _____ Physician's Phone: _____

Are medications to be given during school hours? ☐ Yes ☐ No

(If so, a physician's signature is required for prescription medications.)

Please list below all meds your student currently takes even if not given at school

Medication	Dose	Route		Time given at home	Time given at school
		By mouth	By G-tube		
		By mouth	By G-tube		
		By mouth	By G-tube		
		By mouth	By G-tube		
		By mouth	By G-tube		
		By mouth	By G-tube		
		By mouth	By G-tube		
		By mouth	By G-tube		
		By mouth	By G-tube		
		By mouth	By G-tube		
		By mouth	By G-tube		

NOTE: A new physician's order will be required for each school year and with each medication change thereafter.
*****A medication change will require a new current prescription label from the pharmacy.*****

G- tube and requires feedings at school, please list the feeding requirements: (A Physician's signature is required)

Formula	Amount	Flush	Time given at home	Time given at school

I give permission for the above medications, G-tube and/or treatments to be administered at school. I understand medications (both prescription and over the counter) <u>cannot be brought or sent home with my child</u> and I must personally deliver and pick up the medication(s) from school. This form must be completed.

Parent/Guardian Signature _____ Date:_____

Physician Signature (REQUIRED) _____ Date: _____

Physician Name Printed: _____