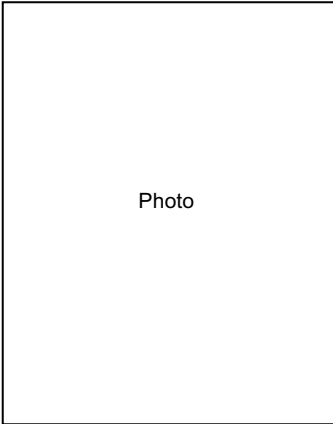


School Nursing Bleeding Disorder EAP

Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

TO BE COMPLETED BY PARENT / GUARDIAN

I, the parent/guardian of _____ date of birth _____ request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I fully realize I can withdraw my request/consent in writing at any future date.



As a parent, I understand my responsibilities are:

1. To provide the school a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours.
3. And that medication will not be administered until signed doctors instructions are at school
4. To inform the school of any medical changes.
5. I will assume responsibility for safe delivery of the medication to school
6. To provide the school with this signed consent form annually and when changes in medication occur.
7. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damage or injury resulting directly or indirectly from this authorization.

Hemophilia: Type- _____ **vonWillebrand Disease:** Type- _____

Other: _____

Activity restrictions: (playground, sports, PE) _____

Medication at School (name)	Dosage /Frequency	Possible side effects

Treatment Plan: (always use universal precautions)

MINOR bleeding episode:	MAJOR bleeding episode
Notify parent if common bleed (nose, mouth, superficial cut) lasting longer than 15 - 20 minutes Cuts: clean, apply pressure, bandage and ice pack Nosebleeds: position child sitting up with head forward and apply pressure for 20 minutes to the cartilage.	Joint Bleeds: The student may report a tingling/bubbling sensation, stiffness or pain. The joint may be warm, stiff and have a decreased ROM. Notify parent and <ul style="list-style-type: none"> R – rest the joint. No weight bearing. I – ice. Apply cold compress C – compression. Apply ace wrap E – elevation. ↑ the affected area to ↓swelling Head, neck, throat and abdominal bleeds can be life threatening. Also any injury to the eye, while not life threatening, is serious. Contact parent and 911 immediately if any of these major injuries.

Signature of Parent/Guardian: _____ Relationship: _____ Date: _____
 Emergency Contact Phone Number _____

PLEASE REVIEW PARENT PROVIDED INFORMATION, SIGN AND RETURN

Physician's name printed _____ Physician's signature _____
 Physicians's address: _____
 Phone: _____ Fax: _____ Date: _____