### Part 1: Student’s Medication Plan
To be completed by licensed health care provider.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>End date for school administration of this medication:</th>
</tr>
</thead>
<tbody>
<tr>
<td>New; the first dose was given at home on date and time:</td>
<td>Renewal</td>
</tr>
</tbody>
</table>

**Is this a standing order?**

- Yes, epinephrine auto injector 0.15 mg: refer to anaphylaxis plan
- Yes, epinephrine auto injector 0.3 mg: refer to anaphylaxis plan
- Yes, albuterol sulfate 90 mcg/inh: refer to asthma action plan
- Yes, other: __________________________
- No

**Name and strength of medication:**

**Dose/route:**

**Time and Frequency at School**
(e.g. 10am and 2pm every day; as needed if standing order)

If a reaction can be expected, please describe:

**Additional instructions or emergency procedures:**

### Part 2a: Student’s Medication Plan
To be completed by licensed health care provider.

**Diagnosis:**

<table>
<thead>
<tr>
<th>This procedure is:</th>
<th>New</th>
<th>Renewal</th>
<th>Change</th>
</tr>
</thead>
</table>

**Treatment:**

**When should treatment be administered at school?**
(e.g. 10am and 2pm every day)

**End date for school administration of this treatment:**

**Additional instructions or emergency procedures:**

Has the student’s Universal Health Certificate form been updated to reflect new health concerns?

- Yes
- No

**Licensed Health Care Provider Office Stamp**

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Provider Phone:</th>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Provider Signature:</th>
<th>Date:</th>
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</tbody>
</table>

**OFFICE USE ONLY**

Medication and/or treatment plan received by Health Suite Personnel.

**Name:**

**Signature:**

**Date:**

DC Health | 899 North Capitol Street NE, Washington, DC 20002 | (202) 442-5925 | dchealth.dc.gov

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