### Part 1: Student’s Medication Plan

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>This medication is:</th>
<th>End date for school administration of this medication:</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>Renewal</td>
<td>Change</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:**

If a reaction can be expected, please describe:

**Additional instructions or emergency procedures:**

### Part 2: Student’s Medical Procedure Treatment Plan

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>This procedure is:</th>
<th>End date for school administration of this treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>Renewal</td>
<td>Change</td>
</tr>
</tbody>
</table>

#### 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**

- Provider Name:
- Provider Phone:
- Provider Signature:
- Date:

**OFFICE USE ONLY**

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

- Name: Signature: Date: