Please complete and return to the Health Clerk at school site

School______________________________ **Date**____________________

MEDICAL MANAGEMENT PLAN / HEALTH CARE PROVIDER'S REPORT

(To be completed by your child's doctor, nurse practitioner or other health care provider)

SCHOOL ACTION PLAN FOR STUDENT WITH SPECIAL HEALTH NEEDS OR CHRONIC HEALTH CONDITIONS

Student's Name ____**Birth date**______________

Diagnosis____

Significant Findings:____

____

Does this condition impact a major life activity? **Yes** **No**

If yes, please state the major activity impacted ____

____

Medications and/or treatment ordered: ____

____

The following are possible signs of an impending crisis:

____

____

Steps to be taken:

1)____

2)____

3)____

4)____

Signs that indicate the need for immediate medical care:______________________________

____

____

Recommendations for physical activity: **unrestricted** **restricted** **(explain)** **supervision** **(explain)**

____

____

Medication: Is the student required to take medication during school hours? **No** **Yes. If so, please fill out the attached medication form. Thank you.**

____________________________	____________________	____________________
Healthcare Provider's Signature	**Telephone**	**Fax**
____________________________	____________________	____________________
Healthcare Provider's Name/Stamp	**Address/City**	**Date**

If you have additional questions contact Educational Services:589 W. Fremont Ave, Sunnyvale, Ca 94087 • (408) 522-2238 • (408) 749-8022 *fax*

Revised: Aug, 2018

Please complete and return to the Health Clerk at school site

FREMONT UNION HIGH SCHOOL DISTRICT

Authorization for Student to Carry Medication in School

PART 1 - STUDENT INFORMATION

Student's Legal Last Name	Student's Legal First Name	Birth Date	Grade	School Year

PART 2 – COMPLETED BY PHYSICIAN

I certify that the above named student must carry the following with him/her at all times while at school and school related activities:

Name of Medication(s)	Medical Condition Requiring Listed Medication(s)

Observable Adverse reaction(s) that might be observable at school:

____

____

Please check each of the following with an X to verify the accuracy of the statement:

- ☐ This condition is such that there is inadequate time for the student to go to the office to obtain the medication.
- ☐ I have instructed the student in the proper administration of this medication and have certified that he/she needs no adult supervision. I have further instructed the student in the dangers of giving the medication to anyone other than himself/herself. I have discussed the above stated risks and liabilities with the parent.

Physician's Printed Name	Physician's Signature	Date

Physician's CA License Number	Physician's Address	Phone Number

PART 3 – COMPLETED BY PARENT

I permit my son/daughter to carry the above listed medication as ordered/approved by his/her physician or surgeon. I authorize the school nurse or other designated school personnel to consult with my child's health care provider regarding any questions that may arise with regard to the medication. My child's physician has fully instructed my son/daughter on the proper administration of this medication, and I certify that he/she does not need adult supervision. I accept responsibility for the appropriate use of this medication by my son/daughter. I am aware of the risks to my son/daughter and other students and assume responsibility for any liability related to the misuse of this medication. I agree to hold the school district and its employees free from any and all responsibility for such services or the manner in which it is administered.

Parent's Signature	Date	Phone Number

PART 4 – COMPLETED BY STUDENT

I have read and understand the medication information above. I will use my medication as I have been instructed and trained by my physician or surgeon. I will keep my medication on my person or in my possession at all times and I will not let anyone else handle or use my medication.

Student's Signature	Date	Phone Number

School Year: ____________

Please complete and return to the Health Clerk at school site

FREMONT UNION HIGH SCHOOL DISTRICT
PERMISSION AND INSTRUCTIONS TO TAKE MEDICATION
During School Hours

Dear Parent/Guardian:
Before medication can be taken during school hours, it is necessary to have specific written orders from your physician and written authorization from you. The school MUST be notified of any alterations to the prescription that is taken at school. In addition, we ask that you notify us of any changes in the medication taken at home that might affect your child's behavior at school. **Medication must be in Original Pharmacy Labeled container with the student's name clearly visible.** Permission must be renewed each school year. Over-the-counter medication will be given only if prescribed by a physician or dentist and in the original container. (California Education Code Section 49423)

Name of Student: ____________________________ Address: ____

Birth date: __________________ School: _____________ Program (if applicable): ______________________________

To be completed by Physician

The above named student is currently under my care and receiving medication(s) for the following condition(s):
(It is necessary for the student to take this medication during school hours.)

____

MEDICATION TO BE TAKEN AT SCHOOL DURING SCHOOL HOURS:

1. **MEDICATION**: ____ **TIME**: __________________

DOSE (Total dose-please give in mg. or ml.) ____________________________________ **ROUTE**: ________________

OBSERVABLE ADVERSE REACTIONS THAT MIGHT BE SEEN AT SCHOOL:

____

MEDICATION WILL CONTINUE FOR: ☐ DAYS ☐ MONTHS ☐ UNTIL: ___________________

2. **MEDICATION**: ____ **TIME:** ________________

DOSE (Total dose-please give in mg. or ml.) ____________________________________ **ROUTE:** ________________

OBSERVABLE ADVERSE REACTIONS THAT MIGHT BE SEEN AT SCHOOL:

____

MEDICATION WILL CONTINUE FOR: ☐ DAYS ☐ MONTHS ☐ UNTIL: ___________________

The school reserves the right to contact the doctor regarding clarification if you are not available.

NOTE TO PARENT: It is your responsibility to provide the required medication(s) in original and individually prescription labeled container(s). Renewal is required for prescription changes and at the beginning of each school year.
AUTHORIZING SIGNATURES: PERMISSION TO **ADMINISTER** THE ABOVE MEDICATION(S) IS HEREBY GIVEN TO THE INSTRUCTIONAL/SCHOOL STAFF AT: ____________________________________

Physician Signature: ______________________________________ Phone: _______________ Date: _________

Physician Name (Please print): _________________________ Phone: ______________ Date: _________

Parent/Guardian Signature: ___________________________________ Day Phone: __________________ Date: _________

Students attending Santa Clara County Programs: Please see Site School Nurse for Specific Instructions.