33.205 Eng Rev. 3/07

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services

Attachment

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Student's Last Name | First Name | Sex | Birth date | School: Kennedy High

Name of Medication | Dose Form: (Tablet, Liquid, Injection, (Inhalant), etc.)

Dosage Prescribed: 2 puffs | Time/Frequency: q 4-6° prn SOB, cough | Route (Mouth, Ear, Eye, Etc.): P.O.

Purpose of medication or diagnosis: ASTHMA wheeze, chest tightness

LICENSED HEALTH CARE PROVIDER (To be completed by a Licensed Health Care Provider)

This student's medical condition requires immediate use of _____ (medication) and the student's well being is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

Please check where applicable:

☐ The medication may have adverse side effects (explain): _____

☐ Special instructions and/or comments: _____

The student for whom this medication is prescribed is under my care.

Print name of licensed health care provider | Signature | Date

Address | City | State | Zip Code | ( ) Telephone

Print name of Supervising Physician (if N.P., Midwife or P.A.) | Furnishing Number (if N.P. or Midwife)

PARENT/GUARDIAN

I request that my child, _____, be allowed to self-administer the medication at school. I assume full responsibility for supplying all medication and agree to the District policies and procedures listed on the reverse side. I request that the school comply with the orders of the above licensed health care provider.

I believe that my son/daughter is physically, mentally, and behaviorally capable of self-administering this medication. I hereby expressly waive and release the Los Angeles Unified School District from any and all rights or claims of any nature whatsoever I may have against the Los Angeles Unified School District, the Board of Education of the Los Angeles Unified School District, and its members, volunteers and employees, arising out of, in connection with, or resulting from the above request.

I give my permission for the exchange of medical information regarding self-administration of medication at school with the authorized health care provider and pharmacist.

Print name of parent or guardian | Signature | Date

( ) Telephone | ( ) Emergency Telephone

SCHOOL PERSONNEL

I have received the request of the parent/guardian and orders of the above licensed health care provider and believe that the above student is physically, mentally, and behaviorally capable of self-administering this medication at school.

Signature of School Principal | Signature of School Nurse | Date

DISTRICT PROCEDURES REGARDING SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

1. Prescription medications must be clearly labeled by a U.S. dispensing pharmacy and contain the following information: (consistent with prescription of authorized licensed health care provider)

   - Student's full name
   - Physician's name
   - Dosage, schedule, route and dose form.
   - Date of expiration of the medication

2. Non-prescription (over the counter) medications that have been authorized by this request, must be in the original container.

3. Requests for Self-Administration of Medication during School Hours must be renewed annually.

4. Parent/Guardian will notify the school nurse or site administrator and provide a new Request for Self-Administration of Medication During School Hours when there is a change in the student's medication, health status or authorized health care provider.

5. Injectable medications, which are to be given on an emergency basis require special arrangements and training of school staff by the credentialed school nurse.

6. A copy of this authorization should be carried with the medication.

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Attachment F

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services

Name of Student / Nombre del estudiante	Birth date / Fecha de nacimiento	School / Escuela
		J.F. Kennedy H.S.

STUDENT CONTRACT FOR SELF-ADMINISTRATION/SELF CARRY OF MEDICATION DURING SCHOOL HOURS

I am requesting to give and/or carry my medication at school and I agree to do the following:

- I will tell the school nurse or H.C.A. (trained school personnel) if there are any problems with my medication, supplies or equipment.
- I will tell the school nurse or H.C.A. (trained school personnel) when I need help or if my symptoms do not get better after taking my medication.
- I will check in with the school nurse about my medication and how often I am using it _____ (frequency).

I understand that any misbehavior with my medication, such as sharing medications with other students or not safely handling equipment, will mean the school administrator or school nurse can take away my self-administration privilege.

ACUERDO ESTUDIANTIL PARA LA POSESIÓN Y SUMINISTRO PROPIO DE MEDICAMENTOS DURANTE EL HORARIO ESCOLAR

Solicito autorización para llevar mi medicamento a la escuela y tomármelo, actuando de conformidad con las siguientes disposiciones:

- Le notificaré a la enfermera escolar o H.C.A. (personal escolar capacitado) en caso de surgirme algún problema con el medicamento, la dosificación, o el equipo.
- Le notificaré a la enfermera escolar o H.C.A. (personal escolar capacitado) si necesitara ayuda o si mis síntomas no mejoraran luego de tomar la medicación.
- Hablaré con la enfermera escolar en referencia a los medicamentos y la frecuencia con que los tomo _____ (frecuencia).

Comprendo que cualquier clase de conducta indebida con los medicamentos, como por ejemplo convidar a otros estudiantes o el uso inapropiado de equipos, llevaría a que el administrador de la escuela o la enfermera escolar me retirara el privilegio de tomarme solo(a) los medicamentos.

Signature of Student / *Firma del estudiante*	Date / Fecha
Signature of School Nurse	Date