# OAKDALE JOINT UNIFIED SCHOOL DISTRICT

District Office 168 South 3rd Avenue (209) 848-4884 Fax: (209) 847-0155

STUDENT PICTURE HERE

## Request for Medication Administration During School Hours
**(Spanish)**

Approved by School Nurse: __________ Date: ___________

Student: ____________________________________ DOB: ________________
Teacher: ____________________________________ Grade: _______________

**TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE** PROVIDER CALIFORNIA CODE OF REGULATIONS TITLE 5, SECTION 601(A)

***Self-Administration** ***ONLY*** *for Auto-Injectable Epinephrine, Inhaled Medication, and Diabetes Medication*

| DX/REASON | MEDICATION | DOSE | ROUTE | TIME | SIDE EFFECTS | For as needed meds, symptoms allowing administration | To be kept in the health office | *Student may self-carry and self-administer |
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If indicated (checked) above, I give permission for the above student to carry and self-administer medication. I have confirmed that the student is capable of appropriate self-administration. If the student is younger than 18, the parent/guardian assumes all liability related to this student's use, timing and technique in self-administering this medication. Other medication(s) will be kept and administered accordingly.

I understand that specialized physical health care services may be performed by unlicensed/non-medical designated school personnel under the training and supervision provided by the school nurse or other health care professional.

Physician Signature: _________________________________ Date: ______________

Physician Name: (Please Print)____________________________________________
Address:_______________________________________________________________
Telephone: ___________________________ Fax: ____________________________ Clinic Stamp Here

**DEBE SER LLENADO POR UN PADRE/GUARDIÁN**

Yo pido que a mi niño se le permita tomar medicamentos durante las horas de escuela de acuerdo a las instrucciones del Doctor del niño. Yo entiendo es mi responsabilidad **traer los medicamentos en su envase original provisto por la farmacia, con el rotulo que contenga el nombre del niño, el nombre del medicamento, la dosis, y las instrucciones** (Código Educacional 49423) y de notificarle a la escuela si hay un cambio de medicamentos o si el niño ya no la necesita. Yo le doy autorización al personal de escuela de asistir con este medicamentos (Código Educacional Sección 49423 y 49480). Doy mi consentimiento para el intercambio de información entre el doctor y/o el farmacólogo y la enfermera de la escuela o su designado para asegurar la administración segura del medicamento(s) incluido(s) en la lista su doctor. **Yo entiendo esta forma debe ser puesta al día cada año y también cuando cambie la receta.** Yo entiendo que desechara los medicamentos que no se recojan una semana después del terminar el año escolar.

Firma del Padre/Guardián: ____________________________________________Fecha: _______________________
Números de teléfono durante el día: _________________________________y______________________________________

STUDENT CONTRACT FOR CARRYING OWN MEDICATION: I ________________________________will be responsible for carrying, administering, and keeping safe at all times, my medication. I will use the medication in the way prescribed by my physician. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing.