Turlock Unified School District

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Please fax or return form to the School Health Office.

Student: _____ Birth Date _____ Male ☐ Female ☐

School: _____ Teacher: _____ Grade _____

School FAX: _____ School Phone: _____

TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER

(Make copies if more than one medication is required.)

Medication Name: _____ Strength (mg, ml, mcg): _____

Dose (# of tab, puffs, etc.): _____ Method of Administration _____

Time of Administration: _____

Start: Immediately_____ Other Date_____ Stop_____ End of Year_____ Other Date/Duration_____

PRN (prescribed as needed)**:** Symptoms _____

Reason for Medication: _____

Restrictions and/or important side effects: ____None Anticipated _____Yes, please describe _____

REQUEST FOR SELF-ADMINISTRATION OF INHALER / EPI-PENS / EPINEPHRINE / INSULIN

This student is both capable and responsible for self-administering auto-injectable epinephrine, inhaled asthma medication and insulin.

_____Yes, unsupervised. _____Yes, supervised. _____No, please indicate additional information: _____

Health Care Provider's Name: _____

Health Care Provider's Signature: _____ Date: _____

Fax#: _____ Phone#: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

PARENT/GUARDIAN CONSENT FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

Parent(s) guardian(s) of _____ request that medication be administered by the school nurse or a member of the school staff if the school nurse is not available. I consent to allow disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel. I will notify the school if the medication has changed or is no longer needed. Medication will be furnished in its pharmacy-labeled container.

Parent/Guardian signature: _____ **Date:** _____ **Phone#:** _____

PARENT/GUARDIAN CONSENT FOR SELF-ADMINISTRATION OF MEDICATION

FOR AUTO-INJECTABLE EPINEPHRINE / INHALED ASTHMA MEDICATION / INSULIN

I hereby consent for my child, _____, to self-administer the following medication during the regular school day or when attending school-related activities: _____Auto-injectable epinephrine _____Inhaled asthma medication _____Other health related medication

I also consent to disclose identifiable health information by the health care provider to the school nurse or other personnel designated by Turlock Unified School District

I acknowledge that I have an obligation to notify the school if my child's medication, dosage, frequency of administration or reason for administration changes during the school year.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to indemnify and hold harmless, release and covenant not to sue the District, it's officers, employees, and agents, for any and all liability, claim or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self-administration of medication

Parent/Guardian Signature _____ **Date:** _____ **Phone#:** _____

Turlock Unified School District

PETICION PARA LA ADMINISTRACION DE MEDICAMENTO EN LA ESCUELA

Por favor enviar por fax o regresarlo a la oficina escolar.

Estudiante: _____ Fecha de Nacimiento _____ Masculino ☐ Femenino ☐

Escuela: _____ Maestro/a: _____ Grado _____

Fax de Escuela: _____ Teléfono de Escuela: _____

TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER

(Make copies if more than one medication is required.)

Medication Name: _____ Strength (mg, ml, mcg): _____

Dose (# of tab, puffs, etc.): _____ Method of Administration _____

Time of Administration: _____

Start: Immediately_____ Other Date_____ Stop_____ End of Year_____ Other Date/Duration_____

PRN (prescribed as needed)**:** Symptoms _____

Reason for Medication: _____

Restrictions and/or important side effects: ____None Anticipated _____Yes, please describe _____

REQUEST FOR SELF-ADMINISTRATION OF INHALER / EPINEPHRINE / INSULIN

This student is both capable and responsible for self-administering auto-injectable epinephrine, inhaled asthma medication or insulin.

_____Yes, unsupervised. _____Yes, supervised. _____No, please indicate additional information: _____

Health Care Provider's Name: _____

Health Care Provider's Signature: _____ Date: _____

Fax#: _____ Phone#: _____

_____

DEBE SER COMPLETADO POR EL PADRE O TUTOR

CONSENTIMIENTO DE PADRE/TUTOR PARA ADMINISTRACION DE MEDICAMENTO POR EL PERSONAL ESCOLAR

Yo / Nosotros, padre(s) o tutor(es) de _____ solicitamos que la medicina será administrada por la enfermera de la escuela o por un miembro del personal escolar si la enfermera de la escuela no está disponible. Doy mi consentimiento para permitir la divulgación de información de salud identificable del proveedor de servicios de salud a la enfermera de la escuela u otro personal escolar designado. Notificare a la escuela si el medicamento ha cambiado o si ya no es necesario. La medicación se entregará en su envase con la farmacia marcado.

Firma del padre / tutor: _____ **Fecha:** _____ **Teléfono:** _____

CONSENTIMIENTO DE PADRE/TUTOR PARA LA AUTO-ADMINISTRACION DE MEDICAMENTO

PARA EPINEFRINA AUTO-INYECTABLE / MEDICAMENTO DE ASMA INHALADA / INSULINA

Doy mi consentimiento para que mi hijo, _____, se auto-administre el siguiente medicamento durante el día escolar o cuando asiste actividades relacionadas con la escuela: _____Epinefrina Auto-Inyectable _____Medicamento de asma inhalada _____Medicamentos relacionados con otros problemas de salud

Doy mi consentimiento para revelar información de salud identificable por el proveedor de cuidado de salud a la enfermera de la escuela u otro personal designado por el District Escolar Unificado de Turlock.

Reconozco que tengo la obligación de notificar a la escuela si la medicación de mi hijo, la dosis, la frecuencia de administración cambia o la razón de los cambios de administración durante el año escolar.

Yo, en nombre de mí mismo, mi hijo, nuestros herederos, albaceas y cesionarios, por lo presente estoy de acuerdo en indemnizar y liberar de responsabilidad, la liberación y pacto de no demandar al Distrito, sus funcionarios, empleados y agentes, de cualquier y toda responsabilidad, reclamación o causa de acción de cualquier naturaleza, incluyendo pero no limitado a la lesiones personales o la muerte, la que puede ser el resultado de la auto-administración de medicamento de mi hijo.

Firma del padre / tutor _____ **Fecha:** _____ **Teléfono:** _____