HAYWARD UNIFIED SCHOOL DISTRICT

SELF-ADMINISTER INHALED ASTHMA MEDICATION AND AUTO-INJECTABLE EPINEPHRINE

Student Name: _____ School: _____ School Year _____

GO#: _____ DOB: _____ Grade: _____ Teacher/room: _____

Students may carry and self-administer inhaled asthma medication and auto-injectable epinephrine. The parent/guardian must release the school district and personnel from liability for any harm resulting from the self-administered medication and provide a release for authorized school personnel to consult with a physician or surgeon. CA EC 49423

Supply of medication must be delivered to the school by a parent or parent designee in a container labeled by the Pharmacist. Label is to include student's name, doctor's name, name and dosage of medication per California Education Code 49423.1 Changes in dosage or time of administration must be verified, in writing, by the physician. Permission is granted to the school nurse to communicate with the physician as needed per California Education Code 49480.

To be completed by PHYSICIAN:

The student named below may carry and self-administer the following emergency medications:

Medication	Dosage	Route	Time/Frequency	Indications/Duration	Possible side effects for this child

☐ _____ **initial** I certify that it is medically necessary and safe for this student to carry their asthma or epinephrine medication and that this student has been trained to safely use it.

X _____ _____

(Licensed Medical Provider's Signature) **(Date)**

_____ _____

(Licensed Medical Provider's Name) **(Licensed Medical Provider's Phone Number)**

_____ _____

(Clinic/Organization/Agency) **(Address)**

To be completed by PARENT/GUARDIAN (ALL MUST be checked and initialed to be valid):

☐ _____ **initial** I am requesting that school personnel assist my student in the administration of the above prescribed medication as directed above.

☐ _____ **initial** I release school personnel from liability from harm caused by the administration of the above prescribed medication.

☐ _____ **initial** I grant permission for the school staff and the Licensed Medical Provider to communicate regarding the student's medical condition and the prescribed medication.

☐ _____ **initial** I understand that my student may be subject to disciplinary action per CA EC 48900 if the medication is used in a manner other than as prescribed.

X _____

(Parent/Guardian Signature) **(Date)** **(Print Parent/Guardian's Name)**

To be completed by STUDENT to SELF-ADMINISTER (ALL MUST be checked and initialed to be valid):

☐ _____ **initial** I have been trained to safely use the above prescribed medication as directed above

☐ _____ **initial** I understand that I may be subject to disciplinary action per CA EC 48900 if the medication is used in a manner other than as prescribed.

☐ _____ **initial** I will **IMMEDIATELY** inform a school staff member if taken.

X _____

(Student Signature) **(Date)** **(Print Student's Name)**

DISTRITO ESCOLAR UNIFICADO DE HAYWARD

auto-administrarse medicamento inhalado para el asma y epinefrina auto-inyectable

Student Name: _____ School: _____ School Year **16/17**

GO#: _____ DOB: _____ Grade: _____ Teacher/room: _____

Los estudiantes pueden cargar y auto-administrarse medicamento inhalado para el asma y epinefrina auto-inyectable. El padre/tutor legal debe librar al distrito escolar y al personal de responsabilidad por cualquier daño resultando del medicamento auto-administrado y proporcionar un comunicado para que el personal escolar autorizado consulte con un el Proveedores médicos con licencia o cirujano. CA EC 49423

El suministro de medicamento debe ser entregado a la escuela por un padre o persona designada por los padres en un envase etiquetado por el farmacéutico. La etiqueta debe incluir el nombre del estudiante, nombre el Proveedores médicos con licencia, nombre y dosis del medicamento, por requisito del Código de Educación de California 49423.1 Cambios de dosis o el horario de administración deben ser confirmados, por escrito, por el Proveedores médicos con licencia. Se le concede permiso a la enfermera de la escuela para comunicarse con el Proveedores médicos con licencia conforme sea necesario, por el Código de Educación de California 49480.

Para ser completado por el Proveedores médicos con licencia (To be completed by Licensed Medical Provider):

The student name below may carry and self-administer the following emergency medications:

Medication	Dosage	Route	Time/Frequency	Indications/Duration	Possible side effects for this child

☐ _____ **initials** I certify that it is medically necessary and safe for this student to carry their asthma or epinephrine medication and that this student has been trained to safely use it.

X _____ _____

(Licensed Medical Provider's Signature) **(Date)**

_____ _____

(Print Licensed Medical Provider's Name) **(Licensed Medical Provider's Phone Number)**

_____ _____

(Clinic/Organization/Agency) **(Address)**

To be completed by PARENT/GUARDIAN (ALL MUST be checked and initialed to be valid):

☐ _____ **iniciales** Solicito que el personal escolar asista a mi estudiante en administrar los medicamentos recetados, anteriormente mencionados, conforme se indica.

☐ _____ **iniciales** Libero al personal escolar de la responsabilidad de los daños causados por la administración del medicamento recetado anteriormente.

☐ _____ **iniciales** Concedo permiso al personal escolar y el Proveedores médicos con licencia para comunicarse sobre la condición médica del estudiante y el medicamento recetado.

☐ _____ **iniciales** Comprendo que mi estudiante puede estar sujeto a medidas disciplinarias por CA EC 48900 si el medicamento es utilizado en una forma distinta a la recetada.

X _____

(Padre/Tutor Legal) **(Fecha)** **(Nombre del Padre/Tutor Legal)**

Para ser completado por el ESTUDIANTE para AUTO-ADMINISTRARSE (TODO debe estar marcado y con iniciales para ser válido):

☐ _____ **iniciales** He sido entrenado para utilizar con seguridad el medicamento recetado como se indica en la parte anterior

☐ _____ **iniciales** Comprendo que yo puedo estar sujeto a medidas disciplinarias por CA EC 48900 si el medicamento es utilizado en una forma distinta a la recetada.

☐ _____ **iniciales** Voy a informar **inmediatamente** a un miembro del personal escolar si se toma

X _____

(Firma del Estudiante) **(Fecha)** **(Nombre del Estudiante/Name of Student)**