

El Camino Real Charter High School
5440 Valley Circle Blvd
Woodland Hills, Ca 91367
Phone: 818-595-7569
Fax: 818-710-9023

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by a CA Licensed Health Care Provider)

Student name _____
Last First Sex Birth date School
Name of medication _____ Date of prescription _____
Dosage prescribed _____ Time schedule at school _____
Dose form _____ Route _____
(Tablet, liquid, injection, inhalant, etc.)
Purpose of medication or diagnosis _____

Licensed Health Care Provider's Recommendations (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/Title Signature Date

Address City State Zip code Telephone
Print name of Supervising Physician _____ (NP, Midwife, PA)
Furnishing Number _____ (NP/Midwife)

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by parent/guardian)

I request that my child _____, be assisted in using prescribed medication at school. I assume full responsibility for supplying all medication and shall deliver it, or have it delivered, to the school by another responsible adult, and agree to the District policies and procedures listed on the reverse side. I give my permission for the exchange of medical information regarding administration of medication at school with the authorized health care provider and pharmacist.

Date Signature of Parent/Guardian/Student 18 years Printed Name

() Home telephone () Work telephone () Cellular telephone

PROCEDURES REGARDING MEDICATION TAKEN 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, and route
 - ◆ How long medication is to be taken? 1 year or short-term: (Date medication is to be discontinued or number of days medication is to be administered.)
2. In addition to a home supply, parent/guardian may request a second labeled bottle from the pharmacy for school use.
3. Non-prescription (over the counter) medications that have been authorized by this request, may be administered at school only if the medication is provided in the original container.
4. Request for Medication to be Taken During School Hours must be renewed annually.
5. Parent/Guardian will notify the school nurse or site administrator and provide a new Request for Medication to Be Taken During School Hours when there is a change in the student's medication, health status or authorized health care provider.
6. The school administrator or the administrator's designee will assume responsibility for placing the medication in a locked cabinet, storage unit or locked refrigerator.
7. The school administrator, the administrator's designee, or school nurse will assume responsibility for returning unused medication to the parent/guardian at the end of the student's school year.
8. If medication must be taken while a student is on a field trip, arrangements must be made through the school nurse.
9. All injectable medications require special arrangements.
 - a. Injectable medications, such as insulin, used on a regular or as needed basis must be administered by licensed health care providers and require special arrangements.
 - b. Injectable medications, which are to be given on an emergency basis, require special arrangements and training of school staff by the credentialed school nurse.
10. Each medication requires a separate written authorization.

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REQUEST FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Student's Last Name _____ First Name _____ Sex _____ Birth date _____ School _____

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

Dosage Prescribed _____ Time/Frequency _____ Route (Mouth, Ear, Eye, Etc.) _____

Purpose of medication or diagnosis _____

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 _____ () Work telephone _____ () Cellular 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 _____

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, and route.
 - ◆ How long medication is to be taken? 1 year or short-term (date medication is to be discontinued or number of days medication is to be administered.)
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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Emergency Health Care Plan

Student _____ DOB _____ Date _____

School _____ Grade _____

Emergency Contacts:

Mother _____ Home _____ Work _____ Cell _____

Father _____ Home _____ Work _____ Cell _____

Physician _____ Phone _____

Medical Diagnosis: **ASTHMA**

Emergency Condition: **Acute respiratory Distress**

Signs/Symptoms: **Acute Asthma Episode**

- a. Difficulty breathing, walking, or talking
- b. Blue or gray discoloration of the lips or fingernails
- c. Failure of medication to reduce worsening symptoms:
Wheezing, coughing, tightness of chest, retractions of chest muscles, _____

School Personnel Action:

- a. Stay with student: encourage to relax using pursed lip and diaphragmatic breathing
- b. Give prescribed medication: _____
- c. Have student drink water at room temperature
- d. Determine respiratory status with peak flow meter if available:
 - Green zone (indicates stability) _____ Action _____
 - Yellow zone (indicates trouble) _____ Action _____
 - Red zone (indicates emergency) _____ Action _____
- e. Reassure student. May return to class when symptoms stop
- f. If symptoms unrelieved after 15 minutes:
 - *STAY WITH STUDENT
 - *Call school nurse, and parent/guardian
 - *Call 911 (EMS)

Individual Considerations: _____

Medications: _____

Known Allergies _____

Triggers _____

Physical activity (P.E.) restrictions/modifications _____

*Requires a doctor's note

We have reviewed this Emergency Health Care Plan:

Principal/Administrator: _____

Nurse: _____

Parent: _____

Teacher: _____

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Name of Student / Nombre del estudiante

Birth date
Fecha de nacimiento

School / Escuela

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 _____ (trained school personnel) if there are any problems with my medication, supplies or equipment.
- I will tell the school nurse or _____ (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 _____ (personal escolar capacitado) en caso de surgirme algún problema con el medicamento, la dosificación, o el equipo.
- Le notificaré a la enfermera escolar o _____ (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