PUPIL SERVICES
JAIMI BRANDL RN, (760) 245-1691 (760) 245-9436 Fax

School Phone # ____________
School Fax # ____________

PHYSICIAN INSTRUCTIONS

For SCHOOL ASSISTED MEDICATION

A. This form must be completed before any medication *(prescription or over-the-counter)* can be given, or taken, at school. ***Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.***

Student Name: ______________________ **Date of Birth:** ____________

PHYSICIAN USE ONLY

1. MEDICATION: ______________ **Dose:** ________ **Reason/Diagnosis:** ____________

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** ____________ **Stop Date:** ________

☐ **If DAILY – Time(s) to be given:** ______________________

☐ **If AS NEEDED (prn) – Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** ____________

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (<u>Not</u> recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): ______________________

2. MEDICATION: ______________ **Dose:** ________ **Reason/Diagnosis:** ____________

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** ____________ **Stop Date:** ________

☐ **If DAILY – Time(s) to be given:** ______________________

☐ **If AS NEEDED (prn) – Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** ____________

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (<u>Not</u> recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): ______________________

Physician Signature: ______________________ ***Date:*** ________

Physician Name: ______________________

Address: ______________________ **Phone:** ____________

City: ______________________ **Zip:** ____________

All medication orders will be automatically <u>discontinued</u> at the end of the school year. New orders are required each school year.

California Education Code section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

*California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

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Parent Request

For Assistance with Medication at School

B. The parent or guardian must complete this page before any medication *(prescription or over-the-counter)* can be given, or taken, at school. ***Signature of parent or guardian is required. This form must be renewed each school year or with any change in medication.***

Student Name: ______________________________ **Date of Birth:** __________________

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

A. **I hereby request that the staff of my child's school assist in giving medication** to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: ____________________ *Date:* ________ **Phone Number:** ____________

B. **For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR <u>SELF-CARRY</u> requests only:** I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication.* I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: ____________________ *Date:* ________ **Phone Number:** ____________

Student Contract – Asthma Inhalers Only

I agree to keep my medication in a safe and secure place, such as on my person, at all times. I agree I will NEVER share my medication with another student. If I am using my inhaler more than once a day, or several times a week, I will speak with the school nurse.

Student Signature: ______________________________ *Date:* ______________

Parent Signature: ______________________________ *Date:* ______________

All medication orders will be automatically <u>discontinued</u> at the end of the school year. New orders are required each school year.

*California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.