



# Request for Administration of Medication at Outdoor School

Foothill Horizons' FAX: (209) 532-0019; TEL: (209) 532-6673; [foothillhorizons@stancoe.org](mailto:foothillhorizons@stancoe.org)



## Student Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Teacher: \_\_\_\_\_

PLEASE RETURN THIS FORM TO YOUR SCHOOL NURSE

### MUST BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER

**MEDICATION INFORMATION:** *Contact Foothill Horizons to make special arrangements if this student needs assistance with injections, intravenous medications, OR takes medications at time other than those that are listed below.\**

Medication 1: \_\_\_\_\_ Strength (mg, ml): \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Refrigerate:  Yes  No Reason/Diagnosis: \_\_\_\_\_ Method/Route:  Oral  Other: \_\_\_\_\_  
 Admin. Time(s):  7 AM Wakeup  8 AM Bkfst  12 PM  1 PM  4 PM  6 PM Dinner  9 PM Bedtime  Other\* \_\_\_\_\_  
 PRN list all symptoms PRN meds can be taken for: \_\_\_\_\_

Medication 2: \_\_\_\_\_ Strength (mg, ml): \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Refrigerate:  Yes  No Reason/Diagnosis: \_\_\_\_\_ Method/Route:  Oral  Other: \_\_\_\_\_  
 Admin. Time(s):  7 AM Wakeup  8 AM Bkfst  12 PM  1 PM  4 PM  6 PM Dinner  9 PM Bedtime  Other\* \_\_\_\_\_  
 PRN (list all symptoms PRN meds can be taken for: \_\_\_\_\_

Medication 3: \_\_\_\_\_ Strength (mg, ml): \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Refrigerate:  Yes  No Reason/Diagnosis: \_\_\_\_\_ Method/Route:  Oral  Other: \_\_\_\_\_  
 Admin. Time(s):  7 AM Wakeup  8 AM Bkfst  12 PM  1 PM  4 PM  6 PM Dinner  9 PM Bedtime  Other\* \_\_\_\_\_  
 PRN (list all symptoms PRN meds can be taken for: \_\_\_\_\_

### REQUEST FOR SELF-ADMINISTRATION OF EMERGENCY MEDICATIONS

**This student is both capable and responsible for self-administering auto-injectable epinephrine and/or inhaled asthma medication:**

Yes, unsupervised  Yes, supervised  No – Please explain why: \_\_\_\_\_  
 This student may carry their emergency medication:  Yes  No – Please explain why: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Email: \_\_\_\_\_  
 Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### MUST BE COMPLETED BY PARENT OR LEGAL GUARDIAN

#### SECTION A: SIGN HERE FOR NON-EMERGENCY MEDICATIONS (MOST MEDICATIONS)

**SECTION A: Parent / Legal Guardian consent for medication to be administered by school personnel**  
 I, the parent(s)/ legal guardian(s) of \_\_\_\_\_, request that medicine 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 or original container.  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

#### SECTION B: SIGN HERE IF YOUR CHILD MAY CARRY HIS/HER OWN RESCUE INHALER, EPI PEN, OR GLUCAGON KIT

**SECTION B: Parent / Legal Guardian consent for self-administered of medication**  
 I hereby consent for my child \_\_\_\_\_, to self-administer his/her  
 ASTHMA INHALER  EPI-PEN  GLUCAGON  
 while attending Outdoor Education at Foothill Horizons. 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 Stanislaus County Office of Education, its 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.  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

### MUST BE COMPLETED BY SCHOOL NURSE

This form was reviewed by the school nurse  These medications were turned into the school nurse.  These medications are current/not expired.

Name: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HOW TO USE THIS FORM

As a school in the state of California, Foothill Horizons must follow the regulations listed below:

California Code of Regulations, Title 5, Education Article 4.1:

- Administering Medication to Pupils or Otherwise Assisting Pupils in the Administration of Medication During the Regular School Day
- §600. CEC Pursuant to Section 49423 49423.1. Section 49423.6. (b)

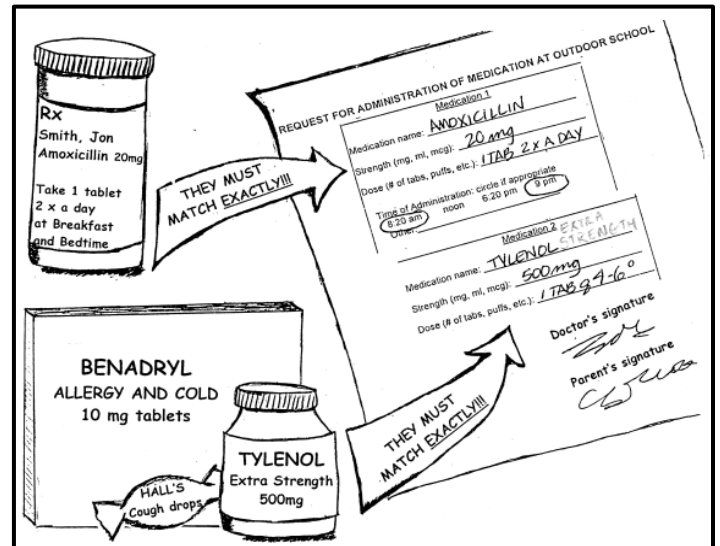
### NOTE TO FAMILIES:

1. Follow the steps below if you want your child to take ANY KIND of medication (**including over the counter medications** like Tylenol, Benadryl, vitamins, Tums, cough drops, etc.).
2. Your child **will NOT be allowed to attend** Foothill Horizons if the medication forms are not filled out completely and correctly.

### INSTRUCTIONS:

#### How to fill out the form

1. Ask your child's Health Care Provider (HCP) fill out the **other side of this form**.
  - a. The label on the medicine and what the HCP writes on the form **must match exactly**.
  - b. If a dosage or scheduled time has changed since the medication was first prescribed, the doctor should call in a new prescription and the pharmacist should print out a new medication label with the current and accurate information to match the HCP's prescription.
  - c. **The HCP must fill the form out completely then sign all forms including those for over-the-counter drugs.**
2. Check the form to make sure the dose and time matches how you administer the medication at home.
  - a. If there are any discrepancies, please ask to your child's HCP to correct the form.
  - b. All medication forms must have a parent/guardian's signature.
3. Return all medication forms to the nurse at least 3 weeks prior to the departure day. The school nurse needs 3 weeks to check the forms and medication information.



#### How to get the medications ready

1. **Only send only medications your child needs!**
2. Write your child's name on any medication that does not have a pharmacy label on it (i.e., over-the-counter medications).
3. Put all your child's medications in one Ziploc bag.
4. Write your child's name and school on the Ziploc bag.
5. The school nurse needs 3 weeks to check the forms and medication information. Return all forms to the nurse at least 3 weeks prior to the departure day.
6. Give the labeled bag with ALL the medications to the school nurse before the day of departure.
  - a. Medications are NOT allowed in your child's luggage.