

**El Camino Real Charter High School**

5440 Valley Circle Blvd.  
Woodland Hills, CA 91367  
Phone: (818) 595-7500  
Fax: (818) 595-7501

**REQUEST FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS**

\_\_\_\_\_  
Student's Last Name                      First Name                      Sex                      Birth date                      School

\_\_\_\_\_  
Name of Medication                      Start Date

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

How long medication is to be taken?  1 year  short-term \_\_\_\_\_  
Date medication to be discontinued or # of days to be given

Purpose of medication or diagnosis \_\_\_\_\_ ICD Code \_\_\_\_\_

**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

## **DISTRICT 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.