WESTSIDE UNION SCHOOL DISTRICT

ORDER FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

In accordance with California Education Code section 49423, this form must be completed by an authorized California healthcare provider (licensed physician, surgeon, dentist, optometrist, podiatrist, nurse practitioner, nurse midwife, physician assistant – California Board of Regulations, Title 5, section 601 [a]) and be on file for any student who requires medication(s) during the regular school day.

_____ _____

Student (Last name, First name) Date of Birth

_____

Grade Teacher / P.E. Teacher School School Phone & Ext School Fax

- I request that my child be assisted at school in taking the medication listed below by authorized personnel.
- Authorization is granted to release this information to appropriate school personnel. I authorize communication between the credentialed school nurse and my child's healthcare provider on matters related to this medication.
- My child is authorized by me to carry and self-administer the medication listed below: □ YES □ No
- I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.
- I understand that "regular school day" does not include After-School childcare programs on a Westside campus.

_____ _____ _____

Parent/Guardian Name (PRINT) Signature Date

_____

Parent/Guardian CELL Phone / Daytime Phone / Email

TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTHCARE PROVIDER:

Name of Medication: _____

Dosage / Form: _____

Times: □ Daily, at _____ time(s) Frequency: □ Every _____ hours, as needed

If this medication is an inhaler: Spacer: □ YES □ NO □ Before P.E., _____ minutes

Reason for Medication (Diagnosis): _____

Possible Adverse Reactions/Side Effects: _____

□ I have instructed the child named above in the proper way to use his/her medication (inhaler, eye drops, skin crème, enzyme supplements). This child has demonstrated the proper technique in administering this medication. It is my professional opinion that he/she **should be allowed to carry and self-administer** this medication.

□ It is my professional opinion that the above named child **should not** be allowed to carry and use this medication by him/herself. This child requires assistance during the regular school day to properly administer medication.

□ This medication may safely and appropriately be administered by unlicensed personnel

_____ _____ _____

Authorized Healthcare Provider Name (PRINT) Signature Date

_____ _____ _____

Phone Number Fax Number Email or Address

_____ _____ _____

Reviewed by Credentialed School Nurse (PRINT) Signature Date

05/2023

Westside Union School District

Guidelines for Students for Self-Administration of Inhalers

The following are guidelines developed for the Westside Union School District students who are directed by their healthcare provider to carry and self-administer medication:

- Receipt of a healthcare provider's statement that the child has demonstrated the proper technique in administering inhaled medication, and written authorization of the parent.

- Inhaler must be properly labeled by the pharmacy, and remain in pharmacy-labeled box or container while carried on campus.

- School nurse will meet with the student and determine if the student is to be allowed to carry the inhaler. The factors that will influence this decision are the student's:

  - Knowledge of the correct dosage, usage, and side effects _____
  - Demonstration of proper technique for inhaler use and storage _____
  - Maturity level _____

- School nurse will outline to the student the parameters of his/her responsibility:
  - Always have the inhaler available when needed _____
  - Do not use the inhaler more frequently than ordered _____
  - Do not share the inhaler with other students _____
  - Notify an adult or come to the Health Office if symptoms continue after using the inhaler _____

- Failure to follow school nurse's direction and endangering himself or others will result in this privilege being revoked. Medication will then be stored in the Health Office.

_____ _____ _____

Student's Name (PRINTED) Student's Signature Date

_____

School Nurse's Initials

For HEALTH OFFICE USE ONLY: □ Inhaler medication stored in Health Office (Date received: _____)
□ Inhaler medication carried by student
□ Inhalers carried by student *and* stored in Health Office