WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT

ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

"Administration of Prescribed Medication for Pupil," California Education Code

"49423 Notwithstanding the provisions of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him/her 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. (Stats. 1976, c. 1010 £ 2.)

I. To be completed by Parent/Guardian

Name of Pupil: ______________________________ Date: ______________

School of Attendance: ______________________________ Grade: _______ D.O.B. _______

I hereby request that authorized school personnel assist this pupil in taking the medication indicated in the matter and dosage prescribed by:

Name of Physician ______________________________

Parent or Guardian's Signature ______________________________ Date ______________

Name of Parent or Guardian ______________________________

Address ______________________________ Telephone: Home: ______________

Work: ______________

II. To be completed by Physician/Health Care Provider

Medication Prescribed: ______________________________ Diagnosis: ______________

Dosage: ______________ Time: ______________ Route: ______________

Date medication to be discontinued: ______________

Restrictions and Cautions ______________________________

This information is to be used only by the person authorized by the school principal to assist the pupil in taking the prescribed medication.

Physician Signature ______________________________ License # ______________ Date ________

Physician's Name ______________________________

Address ______________________________ Telephone ______________________________

III. To be completed by School Principal

Name of Person(s) designated by the school principal to assist the pupil in taking the medication:

____

Principal's Signature ______________________________ Date ______________________________

THIS FORM MUST BE RENEWED ANNUALLY OR WHENEVER THE PRESCRIPTION CHANGES.

WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT
PUPIL SERVICES CENTER
2465 Dolan Way, San Pablo, CA 94806
(510) 307-4646

SELF-ADMINISTRATION OF PRESCRIBED MEDICATION (Insulin)

____________________ School   ____________________ Date

Re: ____________________ Student's Name   ____________________ Birth Date

Dear Doctor:

The parents of the above named student have advised us of your request to have their son/daughter carry insulin on his/her person to use for the treatment of his/her diabetes in the classroom, in any area of the school or school grounds, during any school related activity and, upon specific request by a parent or guardian, in a private location.

In accordance with state law and school board policy, all medication administered during the school day shall be stored in the school health office and administered only when physician's and parents' forms are on file. However, the District will allow this student to carry medication and self-medicate upon approval of both the student's parents and physician. If, in your opinion, this student is able to self-care for his/her diabetes through use of insulin, this student's medical condition requires immediate self-injection of prescribed insulin medication, and this student's well-being is in jeopardy unless the insulin is carried on his/her person, the statement below needs to be signed by you.

Thank you,

School Nurse

____________________ (Student's Name) is under my care for diabetes. His/her condition warrants immediate self-injection of ____________________ (Medication), and it is required that this medication be carried on his/her person. This student has demonstrated knowledge of correct dosage and usage. The medication is to be used by the above student as follows:

________________ Dosage   ________________ Time/Frequency   ________________ Start/Stop Dates

The following is additional information relevant to the self-administration of the medication by the student:

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____________________ Physician's Signature   ____________________ Address

____________________ Telephone Number   ____________________ Date

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We, the parents of ____________________ (Student's Name) desire the ____________________ (School) to comply with the orders of the above physician. We permit an authorized representative of the District to communicate directly with our child's physician, as may be necessary, regarding the physician's above statement. WE ASSUME ALL RESPONSIBILITY AND LIABILITY for the above medication when it is brought on campus by our son/daughter.

____________________ Parent/Guardian   ____________________ Date

WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT
PUPIL SERVICES CENTER
2465 Dolan Way, San Pablo, CA 94806
Phone: (510) 307-4646 Fax: (510) 741-8971

SELF-ADMINISTRATION OF PRESCRIBED MEDICATION (INHALED)

_______________________________ School　　　　_______________________ Date

Re: _______________________________ Student's Name　　　　_______________________ Birth Date

Dear Doctor:

The parents of the above named student have advised us of your request to have their son/daughter carry an inhaler on his/her person to use for the relief of asthma symptoms in the classroom, in any area of the school or school grounds, during any school related activity and, upon specific request by a parent or guardian, in a private location.

In accordance with state law and school board policy, all medication administered during the school day shall be stored in the school health office and administered only when physician's and parents' forms are on file. However, the District will allow this student to carry medication and self-medicate upon approval of both the student's parents and physician. If, in your opinion, this student is able to self-care for his/her asthma through use of the inhaler, this student's medical condition requires immediate inhalation of prescribed inhaler, and this student's well-being is in jeopardy unless the inhaler is carried on his/her person, the statement below needs to be signed by you.

Thank you,　　School Nurse

_______________________________ (Student's Name) is under my care for asthma. His/her condition warrants immediate inhalation of _______________________ (Medication), and it is required that this medication be carried on his/her person. This student has demonstrated knowledge of correct dosage and usage. The medication is to be used by the above student as follows:

_________________ Dosage　　_________________ Time/Frequency　　_________________ Start/Stop Dates

The following is additional information relevant to the self-administration of the medication by the student:

____

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_______________________________ Physician's Signature　　_______________________________ Address

_______________________________ Telephone Number　　_______________________________ Date

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We, the parents of _______________________________ (Student's Name) desire the _______________________________ (School) to comply with the orders of the above physician. We permit an authorized representative of the District to communicate directly with our child's physician, as may be necessary, regarding the physician's above statement. WE ASSUME ALL RESPONSIBILITY AND LIABILITY for the above medication when it is brought on campus by our son/daughter.

____

Parent/Guardian　　　　　　　　Date

DISTRITO ESCOLAR UNIFICADO DE WEST CONTRA COSTA
CENTRO DE SERVICIOS PARA EL ALUMNO
2465 Dolan Way, San Pablo, CA 94806 Télefono: (510) 307-4646 Fax: 741-8971

AUTO-ADMINISTRACIÓN DE MEDICAMENTOS PRESCRIPTOS (INHALADOS)

______________________________ ______________________________
Escuela Fecha

Referente a:______________________________ ______________________________
Nombre del alumno Fecha de nacimiento

Estimado Doctor:

Los padres del alumno anteriormente mencionado nos han informado de su petición de que el estudiante en cuestión posea un inhalador para ser usado en aliviar los síntomas del asma cuando se encuentre en la sala de clases, en cualquier área del establecimiento escolar, en cualquier actividad relacionada con la escuela y en una localidad privada cuando se cuenta con una petición específica del padre o apoderado.

De acuerdo a las leyes del estado y a las normas de la Mesa Directiva Escolar, todos los medicamentos administrados durante el día escolar deben ser guardados en la Oficina Escolar de la Salud y deben ser administrados sólo cuando se encuentren en los archivos escolares del alumno los formularios de los padres y médicos. Sin embargo, el Distrito permitirá que el alumno posea y se auto administre un medicamento si se cuenta con un permiso de los padres del alumno y de un médico. El formulario que se presenta más abajo debe ser firmado por usted si en su opinión existe una de las siguientes características: el alumno es capaz de usar un inhalador para lidiar con sus problemas de asma, la condición médica del alumno requiere la inhalación inmediata de la medicina que se obtiene a través de un inhalador, y el bienestar del alumno se podría perjudicar si este no lleva consigo un inhalador.

Gracias, La enfermera escolar

______________________________ está bajo mi tratamiento en lo que respecta a asma. Su condición
Nombre del alumno

requiere inhalación inmediata de ______________________________, y es necesario que esta medicina esté
Medicamento

con él/ella en todo momento. Este alumno sabe como usar este aparato y la dosis correcta. La medicina es para ser usada por el alumno anteriormente mencionado, de la siguiente manera:

______________________________ ______________________________ ______________________________
Dosis Tiempo/Frequencia Fechas de comienzo y término

La siguiente información adicional es referente a la auto administración del medicamento por el alumno:

____

____

______________________________ ______________________________
Firma del médico Dirección

______________________________ ______________________________
Número de teléfono Fecha

Nosostros los padres de ______________________________ deseamos que ______________________________
Nombre del alumno School

cumpla con las órdenes del medico mencionadas anteriormente. Le permitimos a un representante autorizado del Distrito que se comunique directamente con el medico de nuestro hijo, cuando sea necesario, sobre las indicaciones expuestas anteriormente. NOSOTROS ASUMIMOS TODA LA RESPONSABILIDAD de lo que podría ocurrir con el medicamento mencionado cuando nuestro hijo o hija lo lleva al establecimiento escolar.

______________________________ ______________________________
Firma del padre Fecha

DISTRITO ESCOLAR UNIFICADO DE WEST CONTRA COSTA

CENTRO DE SERVICIOS PARA EL ALUMNO
2465 Dolan Way, San Pablo, CA 94806
(510) 307-4646

AUTO-ADMINISTRACIÓN DE MEDICAMENTO PRESCRITO (Insulina)

______________________________ ______________________________
Escuela Fecha

Re: ______________________________ ______________________________
Nombre del alumno Fecha de nacimiento

Estimado Doctor:

Los padres del alumno arriba mencionado nos han avisado sobre su petición de que su hijo/hija tenga que llevar insulina en su persona para utilizar en el tratamiento de su diabetes en el aula, en cualquier área de la escuela o en el patio de la escuela, durante cualquier actividad relacionada con la escuela y bajo la petición específica del padre/madre o encargado, en una ubicación privada.

De acuerdo a la Ley de Estado y a las normas de la Mesa Directiva Escolar, todos los medicamentos administrados durante el día lectivo serán almacenados en la Oficina de la salud de la escuela y administrado sólo cuando los formularios del médico y de los padres están en el archivo. Sin embargo, el Distrito permitirá a este alumno llevar su medicamento y auto medicarse con la aprobación de los padres del alumno y del médico. En su opinión, si este alumno puede cuidar su diabetes a través del uso de insulina, y esta condición médica del alumno requiere auto-inyección inmediata del medicamento prescrito de insulina, y el bienestar de este alumno está en riesgo a menos que la insulina sea llevada en su persona, la declaración de abajo necesita ser firmada por usted.

Muchas gracias,

Enfermera escolar

______________________________ is under my care for diabetes. His/her condition
Student's Name

warrants immediate self-injection of ______________________, and it is required that this
Medication

medication be carried on his/her person. This student has demonstrated knowledge of correct dosage and usage. The medication is to be used by the above student as follows:

______________ ______________ ______________
Dosage Time/Frequency Start/Stop Dates

The following is additional information relevant to the self-administration of the medication by the student:

____

____

______________________ ______________________
Physician's Signature Address

______________________ ______________________
Telephone Number Date

Nosotros, los padres de ______________________ deseamos que la escuela ______________
Nombre del alumno

cumpla con las órdenes del médico nombrado arriba. Damos permiso para que un representante autorizado del Distrito se comunique directamente con el médico de nuestro hijo/a, si fuese necesario, con respecto a la declaración de arriba. NOSOTROS ASUMIMOS TODA RESPONSIBILIDAD Y OBLIGACIÓN por el medicamento arriba mencionado cuando es traído al terreno escolar (tanto en el edificio como en el patio) por mi hijo/a.

______________________________ ______________________
Padre/madre/encargado Fecha