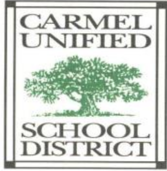


CARMEL UNIFIED SCHOOL DISTRICT- HEALTH SERVICES

AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL

(PRESCRIPTION OR OVER THE COUNTER)

California Education Code 49423 provides that 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 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/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement. *California Education Code 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.

All medication orders will be automatically discontinued at the end of the school year, or at end the end of summer school, if needed. New orders are required each school year.

AUTHORIZED HEALTH CARE PROVIDER USE ONLY

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER (California licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants- California Code of Regulations, Title 5, section 601[a])

Students Name: ______________________________ **DOB:**__________________

Medication: ____________________**Dose:**__________**Reason/Diagnosis:**________________

Route: ☐ **Oral** ☐ **Inhale** ☐ **Nasal** ☐ **Topical** ☐ **Intramuscular** ☐ **Subcutaneous** ☐ **Other**__________

Medication Start Date: ____________________ **Stop Date:** ____________________

☐ **If DAILY, Time(s) to be given:** ________________________

☐ **If AS NEEDED (prn), Frequency:** ☐ **Every 4 to 6 hrs.** ☐ **Every 6 to 8 hrs. Other** ______________

Others instructions or precautions-possible reactions: ______________________________

Health Care Provider Signature: ________________________ **Provider License #:**__________

Health Care Provider Name (Print): ____________________ **Date:** __________________

Address: ____ **Phone:** __________________

City & Zip: ______________________________________ **Fax:** ____________________

School Contacts

Carmel River Elementary School- Melissa Anderson, LVN (831.624.4609)

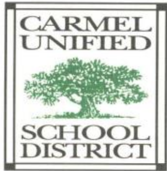
Tularcitos Elementary School- Ludmilla Nelson, LVN (831.620.8195)

Captain Cooper Elementary School- Carolyn Sinclair, Health Aide/ Debbie Taylor, RN (831.667.2452)

Carmel Middle School- Courtney Day, Health Aide/ Debbie Taylor, RN (831.624.2785)

Carmel High School- Kathy Lockwood, Health Aide/ Debbie Taylor, RN (831.624.1821)

Carmelo Child Development- Debbie Taylor, RN (831.624.8047)



CARMEL UNIFIED SCHOOL DISTRICT- HEALTH SERVICES

AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL

(PRESCRIPTION OR OVER THE COUNTER)

Parent Request – PARENT COMPLETES THIS PAGE

Request for school personnel to administer medication

Responsibility of the Parent or Guardian:

1. Parents/guardian shall be encouraged to cooperate with the physician to develop a schedule so the necessity for taking medication at school will be minimized or eliminated.
2. Parents/guardian will assume full responsibility for the supply and transportation of all medications.
3. Parents/guardian may administer medication to their student on a scheduled basis arranged with the school. Students are not permitted to carry prescribed or over-the-counter medication on school campus.
4. Parents/guardians MUST pick up unused medications from the school office during and at the close of the school year. **Medication remaining after the last day will be discarded.**
5. Each medication is to be in a separate pharmacy container prescribed for the student by a California licensed health care provider.
6. Each over-the-counter medication is to be in its original sealed container and prescribed for the student by a California licensed health care provider.

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

Student Name: ____ Date of Birth: ______________________
(Please Print)

Parent Request for School Administer 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 inhalers/epinephrine auto-injectors/diabetic supplies accompanied by appropriate physician instructions).

All medication orders will be automatically discontinued at the end of the school year-summer school. New orders are required each school year

For **ALL MEDICATIONS KEPT IN THE SCHOOL HEALTH OFFICE** only: I hereby request that the staff of my student's school assist in giving medication to my student 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/Guardian Signature: ____ Date: _______________

Parent/Guardian Name (Print): _____________________________________ Phone: ______________

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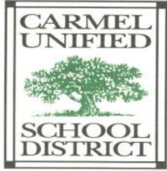

CARMEL UNIFIED SCHOOL DISTRICT- HEALTH SERVICES

AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL

(PRESCRIPTION OR OVER THE COUNTER)

Authorization to Self-Carry

For **INHALERS/EPINHEPHRINE AUTO-INJECTORS/DIABETIC SUPPLIES if *SELF CARRY only***: I hereby request that my student carry and self-administer his/her inhaler/auto-injector/diabetic supplies. 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.

Parent/Guardian Signature: ____ Date: ______________

Parent/Guardian Name (Print): _____________________________________ Phone: ______________

Student Contract – Inhalers/Epinephrine Auto-Injectors/Diabetic Supplies Grade 5th-12th 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 if I am not feeling better after using my inhaler, I will come to the health office. If I need to use my epinephrine auto-injector I will notify school personnel immediately so that emergency services can be contacted.

Student Signature: ____ Date: _____________

Print Name: ____

Medication:________________________Dose:____________Reason/Diagnosis:_______________________

Route: ☐ Oral ☐ Inhale ☐ Nasal ☐ Topical ☐ Intramuscular ☐ Subcutaneous ☐ Other_____________

Medication Start Date: _________________________ Stop Date: ________________________

☐ **If DAILY, Time(s) to be given: ______________________________**

☐ **If AS NEEDED (prn), Frequency: ☐ Every 4 to 6 hrs. ☐ Every 6 to 8 hrs. Other_________________**

Health Care Provider Signature: ____________________________ Provider License #:____________

Health Care Provider Name (Print): _________________________ Date: ________________________

Address: ____ Phone: ______________________

City & Zip: ____ Fax: _________________________

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Revised 8/8/18