Medication at School

WASHINGTON UNIFIED SCHOOL DISTRICT

Student Name: ___________________________________ DOB: ______________ Grade: ___________

Dear Parent:
Education Code Section 49423 defines certain requirements for administration of medication. "…any pupil who is required to take, during the regular school day, medication prescribed for him or her by a physician and surgeon, may be assisted by the school nurse or other designated school personnel or may carry and self-administer inhaled asthma medication if the school district receives (1)….a written statement from the physician and surgeon detailing the name of medication, method, amount, and time schedules by which the medication is to be taken and (2) a written statement from the parent, foster parent, or guardian of the pupil requesting that the school district assist the pupil in the matters set forth in the statement of the physician and surgeon."

The medication must be clearly labeled and sent to school in the container from the pharmacy.

At the beginning of each year or upon entry to a school a Medication at School form must be completely renewed.

PARENT'S REQUEST

We the undersigned, who are parents/guardians of ____, request that the school nurse or designated school personnel assist the pupil in matters set forth in the statement of the physician and/or surgeon. If so approved by the physician, we do consent that our child carry and self-administer inhaled asthma medication. In the event of an unseemly, subsequent, adverse reaction, it is understood that the school personnel and the school district will not be held responsible or civilly liable for carrying out this request. We also give permission for the school nurse/designated school personnel to consult with the health care provider regarding any questions that may arise with regard to the medication listed below. We also agree to immediately notify the school nurse and/or designated school personnel if there is any change in the pupil's medication, dosage, hour, method of administration, time limit, or condition for administering.

____ _____________________________ ____________________

Signature *Phone Number* *Date*

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL (LHP)
PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

Name of Medication: ____ Dosage: ________________________

Time of Administration: _________________ If given PRN, specify the minimum length of time between doses: _______________

Method of Administration: ____________________ Possible medication side effects:_____________________________________

If applicable, I request and authorize this student to keep prescribed inhaled asthma medication on his/her person. **Y / N**

I request and authorize that this student has been trained, and is able to self-administer their medication. **Y / N**

Diagnosis or condition for medication: ____

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from ____________ (date) to ____________ (date) **(not to exceed current school year)**. There exists a valid health reason which may make administration of the medication advisable during school hours.

____ ____________________________ ____________________

Signature Licensed Health Professional (LHP) *Telephone Number* *Date*

For additional information, please contact the below school personnel:

Name:_____________________________________ Title:________________________ Phone:____________________

American Union Elementary School
2801 W. Adams Ave.
Fresno, CA 93706

Phone: (559) 495-5650
Fax: (559) 267-5708

West Fresno Elementary School
2910 S. Ivy Ave.
Fresno, CA 93706

Phone: (559) 495-5635
Fax: (559) 233-6446

West Fresno Middle School
2888 S. Ivy Ave.
Fresno, CA 93706

Phone: (559) 495-5635
Fax: (559) 485-3006

Washington Union High School
6041 S. Elm Ave.
Fresno, CA 93706

Phone: (559) 485-8805
Fax: (559) 485-4435