long beach unified school district

Office of School Support Services
***STUDENT HEALTH SERVICES***

# MEDICATION AT SCHOOL – PARENT'S REQUEST

***(A separate form is needed for each medication)***

Dear Parent/Guardian,

Medical treatment is the responsibility of the parent and family physician. Medications are rarely given at school; the only exceptions involve special or serious problems where it is deemed absolutely necessary by the family physician. The parent is urged to work out a schedule, with the help of the family physician, for giving medication at home, outside school hours if possible.

The law allows for school personnel to assist in carrying out a physician's recommendation; therefore, in the absence of the school nurse, the principal, teacher, secretary or clerk may be the person administering the medication. If medication is to be administered at school, you **must** provide the school with **all** of the following:

1. A written statement from the physician clearly specifying the condition for which the medication is to be given, dosage, time, and specific instructions for emergency treatment in case of an allergic reaction must be provided to the district. If a nurse practitioner (NP) or a physician's assistant (PA) writes the medication order, their California furnishing number and the name of their supervising physician **must** be included.

2. The parent/guardian must sign a request for administration of medication at school.

3. Medication needs to be delivered to the school by the parent/guardian or other responsible adult.

4. Medication must be in the original pharmacy labeled container, clearly stating all prescription information (name of medication, dosage, how to be given and the time). It is suggested you request two containers from your pharmacist – one for home and one for school.

5. Original copy of a FAX order **must** be mailed to the school within 5 days.

Please discuss your physician's instructions with your child so that he/she is aware of the time medication is due. In the case of a disabled student who requires medication during the school day to effectively participate in the educational program, district personnel will ensure that it is administered with assistance on a consistent basis. Please arrange with the school to pick up leftover medication by the last day of the school year. Medication(s) left at school at the end of the school year will be discarded.

**THIS REQUEST IS VALID FOR THIS SCHOOL YEAR ONLY. ANY TIME THERE IS A CHANGE IN MEDICATION (name, dose, time, etc.), NEW PHYSICIAN'S AND PARENT'S REQUEST FORMS ARE REQUIRED.**

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**Parent/Guardian Agreement:**

I, the parent/guardian of _____ , Birthdate _____ request medication be administered to my child in accordance with the physician's written instructions on the reverse side of this form. I understand that if the school nurse is not available, other trained school personnel will administer the medication. I will notify the school immediately if I change physicians, or when the medication is changed in any way (e.g., dose, method of administration, time, etc). I also authorize, as needed, the sharing of information related to my child's health between the school nurse and the health care provider listed on the back of this form.

Parent/guardian signature_____ Date_____

Home Phone_____ Work phone_____Cell phone_____

**(PHYSICIAN MUST COMPLETE OTHER SIDE)**

**MEDICATION AT SCHOOL – PHYSICIAN'S REQUEST**
***(A separate form is needed for each medication)***

Student's Name_____ Birthdate _____

**DIAGNOSIS** for which medication is to be given: (If for an allergy, please specify what type - localized, generalized, mild, severe, etc).

_____

**PLEASE PRINT:**

Name of medication_____

Dose_____

Specific time (e.g. 10 am, noon, etc)_____
(For PRN medications, please indicate why medication should be given (e.g. for wheeze, headache, etc.)

Reactions that need to be reported to the physician_____

_____

Medication to be continued as above until this date:_____

**PHYSICIAN'S AGREEMENT:** This medication cannot be scheduled for other than during school hours, and I understand that the medication may be administered by non-medically trained school personnel whenever necessary.

_____ Date:_____
Signature of licensed physician ***(NP must have physician's co-signature or name stamp of physician. NP must have license number.)***

_____ Phone:_____
Please **PRINT** name of licensed physician and surgeon)

_____
Address/facility stamp **(medication will <u>not</u> be accepted without stamp)**

Nurse practitioner (NP) or physician's assistant (PA) <u>must</u> complete:

Printed NP/PA name_____ CA furnishing number_____

Signature of NP/PA_____ Date_____

Name of supervising physician_____

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(For school use only)

Principal's Signature_____ Date_____

School Nurse's Signature_____ Date_____

**(PARENT/GUARDIAN MUST SIGN ON THE OTHER SIDE)**