

Student's Name _____ Birthdate _____

Dear Parent/Guardian/Physician:

California 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/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 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 matter set forth in the physician's statement." CUSD Board Policy No. 2401 does not allow students to administer their own medication without written permission as stated above.

Additionally, CUSD Administrative Regulation No. 2401 indicates that school personnel are prohibited from administering any over-the-counter or prescription medications including aspirins, vitamins, antihistamines, etc. unless the medication is accompanied with written permission from both the parent/guardian and physician. The medication must be clearly labeled and sent to school in a container from the pharmacy and will be kept in the school office unless otherwise directed by the physician.

At the beginning of each school year or upon entry into school, a "MEDICATION AT SCHOOL" form must be completely renewed.

If you require any additional information regarding the above, please contact the school nurse or other authorized school personnel:

School Nurse/School Office Personnel _____ Date _____
School: _____

PARENT/GUARDIAN REQUEST

We, the undersigned, who are the parents/guardian of _____ request that the school nurse or designated school personnel assist our child in the matter set forth by the physician's statement. In the event of an untoward or subsequent reaction, it is understood that the school personnel will in no way be held responsible for carrying out this request.

Signature of Parent/Guardian _____ Date _____

Medication is needed for the following reason(s): _____

<u>NAME OF MEDICATION</u>	<u>DOSAGE</u>	<u>TIME(S) TO BE GIVEN</u>

Time limit on medication (i.e., 10 days, 1 month, current school year): _____
PE instructions: Self-pace: Yes / No (circle one)

For Students with Asthma: **SEE BACKSIDE OF THIS FORM FOR ASTHMA ACTION PLAN**

PE instructions: Self-pace: _____

Inhaler Instructions: Student may / may not (circle one) carry inhaler.
Student has / has not (circle one) demonstrated to provider appropriate use of inhaler/spacer.

NOTE - To Physician of asthma student: My signature below indicates I am in agreement with the Asthma Action Plan as written on the backside of this form.

Physician's Name (please print or type) _____

Physician's Signature _____ Date _____

Address: _____ Phone _____

SCHOOL ASTHMA ACTION PLAN

For School Year _____

Student Name _____

Home phone _____

Parent/Guardian Name _____

Work phone _____

Cell phone _____

Doctor Name _____

Office phone _____

ASTHMA SEVERITY:

___ Mild / Intermittent ___ Mild / Persistent ___ Moderate / Persistent ___ Severe / Persistent

Asthma symptoms can be/are triggered by: _____

PREDICTED PEAK FLOW: _____ **PERSONAL BEST PEAK FLOW:** _____ Date: _____

GREEN ZONE – Peak Flow is between _____ (80%) and _____ (100% of personal best)

May return to class

YELLOW ZONE CAUTION: Peak flow is between _____ (50% of personal best) and _____ (80% of personal best)

1. Take Albuterol or _____ Inhaler _____ puffs **OR** _____ solution ___ ml by nebulizer.

Rest and drink water

2. If symptoms are better or if the peak flow is back in the Green Zone within 15-20 minutes.

Notify Parent

May return to class

No strenuous activity for the day

RED ZONE –MEDICAL ALERT! GET HELP! CALL 911 AND DO NOT LEAVE STUDENT ALONE!

Peak flow is below _____ (50% of personal best)

1. Take Albuterol or _____ Inhaler _____ puffs every _____ minutes up to _____ puffs **OR** _____ solution ___ ml by nebulizer.
2. **CALL PARENT/GUARDIAN IMMEDIATELY**
3. **REST AND GIVE SIPS OF WATER BETWEEN PUFFS**
4. **MONITOR UNTIL PARAMEDICS ARRIVE!**

My child may carry and self-administer asthma medications and my signature below indicates that I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications:

_____ Yes _____ No

Parent/Guardian Signature

Date

PHYSICIAN/HEALTH CARE PROVIDER

My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with State laws and regulations.

Physician/Health Care Provider Signature

Date