NS MT-1 CLOVIS UNIFIED SCHOOL DISTRICT Rev. 1/09

MEDICATION AT SCHOOL

Student's Name _____ Sex: M F 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 me at _____ (phone) _____(fax)

School Nurse _____ Date _____

School Name/Address _____

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): _____

NAME OF MEDICATION	DOSAGE	TIME(S) TO BE GIVEN

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

Revised 8/30/05