ALLEGIANCE STEAM ACADEMY ASSISTANCE WITH MEDICATION FORM

☐ **Allegiance STEAM Academy, Chino · 5862 C. Street Chino CA 91710 · Ph 909-465-5405 Fax 630-556-8995**

☐ **Allegiance STEAM Academy, Fontana · 7420 Locust Ave Fontana CA 92336 · Ph 909-258-9937**

PHYSICIAN INSTRUCTIONS - FOR SCHOOL ASSISTED MEDICATION

A. This form must be completed before any medication *(prescription or over-the-counter)* can be given, or taken, at school.
Signatures of both physician and parent/guardian are required. This form must be renewed annually and with any change in medication.

Student Name: _____ **DOB:** _____ **Date:** _____

1. MEDICATION: _____ **Dose:** _____
May Substitute Generic: _____**Yes** _____**No**
Reason/Diagnosis:_____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other: _____
Med Start Date: _____ **Discontinue Medication at end of school year July 31,** _____ **or** _____

☐ **If DAILY ~ Time(s) to be given:** _____
☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs** ☐ **Other:**
_____

☐ ***Self carry – for asthma inhalers or epinephrine auto-injectors ONLY. Students demonstrate competence.**
o (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

2. MEDICATION: _____ **Dose:** _____
May Substitute Generic: _____**Yes** _____**No**
Reason/Diagnosis:_____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other: _____
Med Start Date: _____ **Discontinue Medication at end of school year July 31,** _____ **or** _____

☐ **If DAILY ~ Time(s) to be given:** _____
☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs** ☐ **Other:**
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☐ ***Self carry – for asthma inhalers or epinephrine auto-injectors ONLY. Students demonstrate competence.**
o (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

3. MEDICATION: _____ **Dose:** _____
May Substitute Generic: _____**Yes** _____**No**
Reason/Diagnosis:_____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other: _____
Med Start Date: _____ **Discontinue Medication at end of school year July 31,** _____ **or** _____

☐ **If DAILY ~ Time(s) to be given:** _____
☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs** ☐ **Other:**
_____

☐ ***Self carry – for asthma inhalers or epinephrine auto-injectors ONLY. Students demonstrate competence.**
o (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

PHYSICIAN/HCP OFFICE STAMP

Physician's/HCP name (printed) _____
Physician Signature: _____
Date: _____

Address: _____
Phone: _____ Fax _____

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

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Parent Request
For Assistance with Medication at School

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

Parent Request for School Assistance with 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 (except for asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions). **I hereby authorize an exchange of information between the school health office and the physician/HCP listed on this form regarding the prescribed medication(s). At school/school functions, I request that medication(s) be administered to my child by school staff or field trip/camp staff in accordance with the physician's/HCP written instructions on this from.**

A. I hereby request that the staff of my child's school assist in giving medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information regarding this form as needed.

Parent or Guardian Signature: _____ ***Date:*** _____ **Phone Number:** _____

B. For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR SELF-CARRY requests only: I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. 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. *I **also give permission to contact the physician for consultation and exchange of information regarding this form as needed.**

Parent or Guardian Signature: _____ ***Date:*** _____ **Phone Number:** _____

Student Contract – Asthma Inhalers 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 several times a week, I will speak with the school nurse/health technician/staff.

Student Signature:		***Date:***	
Parent Signature:		***Date:***	
Health Tech/ School Nurse Signature		***Date:***	

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.
California Education Code section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for him 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 such 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 matters set forth in the physician's statement.

FOR OFFICE USE ONLY

Date	Medication/Supplies	Exp. Date	Amt. Rec'd	Parent/Guardian Signature	Signature of Receiver

Medication procedures, parent authorization, and physician's HCP order(s) for medication(s) have been verified by the School Health Technician, Nurse, or Principal. *If not brought in by parent, verify receipt and amount with parent by telephone

* California Education Code section 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.