NS MT-1 CLOVIS UNIFIED SCHOOL DISTRICT Rev. 5/15

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 _____

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

FOR STUDENTS WITH ALLERGIES OR EPIPENS : REVERSE SIDE OF THIS FORM MUST BE COMPLETED BY PHYSICIAN

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)

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 EPIPEN student: My signature below indicates I am in agreement with the Action Plan as written on the backside of this form.

****

Physician's Name (please print or type) _____

Physician's Signature _____ Date _____

Address: _____ Phone _____

Anaphylaxis Emergency Action Plan

Student Name: _____DOB_____ Grade_____

Severe Allergy To: _____ Asthma: Yes ☐ (HIGHER RISK FOR SEVERE REACTION) No ☐

Step 1- Treatment

WHEN IN DOUBT, TREAT FOR ANAPHYLAXIS

Asthma inhaler and/or antihistamines cannot be relied upon to replace epinephrine in treating anaphylaxis.

Symptoms of Anaphylaxis
• Mouth: Itching, tingling, or swelling of lips, tongue, mouth
• Skin: Hives, itchy rash, swelling of the face or extremities
• Gut: Nausea, abdominal cramps, vomiting, diarrhea
• Throat:* Tightening of throat, hoarseness, hacking cough
• Lung:* Shortness of breath, repetitive coughing, wheezing
• Heart:* Weak or thread pulse, low blood pressure, fainting, pale, blueness
• Other:* _____

Dosage: (student may/may not carry - circle one)

1. Administer Epinephrine: _____ mg.
   a. Administer second dose of epinephrine if: _____
2. Administer Antihistamine: _____Dose: _____Route: _____
3. Other Medication: _____ Dose: _____Route: _____

Step 2- Emergency Calls

1. CALL 911 (State that epinephrine has been given and additional epinephrine may be given)
2. Health office/School Nurse Phone Number: _____
3. Parent/Guardian: _____ Phone Number: _____

Special Meal Accommodations (Annual update needed only if diet order changes)

Food allergies or other meal accommodations needed:

☐ Participant has a disability or a medical condition (major life activity affected) and *requires* a special meal or accommodation. Schools and agencies participating in federal programs must comply with requests for special meals and any adaptive equipment.

* **A licensed physician is required to complete and sign this for a child that has a disability. (Sign below)**

If participant has a disability, provide a brief description of participant's major life activity affect by the disability:

_____

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests.

* **A licensed physician, physician's assistant, or nurse practitioner must sign this form. (Sign below)**

Diet prescription and/or accommodation: (please describe in detail to ensure proper implementation)

Foods to be omitted:

_____

Foods to be substituted:

"This institution is an equal opportunity provider and employer"

Signature of Medical Authority*_____Date:_____