LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

LOS ANGELES UNIFIED SCHOOL DISTRICT

Student Health and Human Services

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Student's Last Name_____ First Name_____Gender_____Birth Date_____School_____

Name of Medication_____ Start Date _____

Dosage Prescribed_____Time/Frequency_____Route_____
(Mouth, Ear, Eye, Etc.)

How long is medication to be taken? ☐ 1 year ☐ short-term _____
Date medication to be discontinued or # of days to be given

Purpose of medication or diagnosis_____ ICD Code _____

LICENSED HEALTH CARE PROVIDER (To be completed by a CA Licensed Health Care Provider, or a physician or surgeon from Mexico contracted with a bi-national health plan who prescribes self-administered, inhaled asthma medication in accordance with C.E.C. Section 49423.1)

This student's medical condition requires immediate use of_____(medication) and the student's wellbeing is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

Please check where applicable:

☐ The medication may have adverse side effects (explain): _____ Special

☐ Instructions and/or comments: _____

The student for whom this medication is prescribed is under my care.

Print name of licensed health care provider_____ Signature_____ Date_____

_____ (___)_____
Address City State Zip Code Telephone

_____ _____
Print name of Supervising Physician (if N.P., Midwife or P.A.) Furnishing Number (if N.P. or Midwife)

PARENT/GUARDIAN

I request that my child,_____, be allowed to self-administer the medication at school. I assume full responsibility for supplying all medication and agree to the District policies and procedures listed on the reverse side. I request that the school comply with the orders of the above licensed health care provider.

I believe that my son/daughter is physically, mentally, and behaviorally capable of self-administering this medication. I hereby expressly waive and release the Los Angeles Unified School District from any and all rights or claims of any nature whatsoever I may have against the Los Angeles Unified School District, the Board of Education of the Los Angeles Unified School District, and its members, volunteers and employees, arising out of, in connection with, or resulting from the above request.

I give my permission for the exchange of medical information regarding self-administration of medication at school with the authorized health care provider and pharmacist.

_____ _____ _____
Print name of parent or guardian Signature Date

(___)_____ (___)_____ (_____)_____
Telephone Work telephone Cellular telephone

SCHOOL PERSONNEL

I have received the request of the parent/guardian and orders of the above licensed health care provider and believe that the above student is physically, mentally, and behaviorally capable of self-administering this medication at school.

_____ _____ _____
Signature of School Principal Signature Date

DISTRICT PROCEDURES REGARDING SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

1. Prescription medications must be clearly labeled by a U.S. dispensing pharmacy and contain the following information: (consistent with prescription of authorized licensed health care provider)

    - Student's full name
    - Physician's name
    - Dosage, schedule, and route.
    - How long medication is to be taken? 1 year or short-term (date medication is to be discontinued or number of days medication is to be administered.)

2. Non-prescription (over the counter) medications that have been authorized by this request, must be in the original container.

3. Requests for Self-Administration of Medication during School Hours must be renewed annually.

4. Parent/Guardian will notify the school nurse or site administrator and provide a new Request for Self-Administration of Medication During School Hours when there is a change in the student's medication, health status or authorized health care provider.

5. Injectable medications, which are to be given on an emergency basis require special arrangements and training of school staff by the credentialed school nurse.

6. A copy of this authorization should be carried with the medication

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This student's medical condition requires immediate use of _____(medication) and the student's well-being is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

Please check where applicable:

☐ The medication may have adverse side effects (explain): _____

☐ instructions and/or comments: _____

The student for whom this medication is prescribed is under my care.

Print name of licensed healthcare provider _____ Signature _____ Date _____

Address _____ City _____ State _____ Zip Code _____ ( ) Telephone _____

Print name of Supervising Physician (if N.P., Midwife or P.A.) _____ Furnishing Number (if N.P. or Midwife) _____

PADRE/MADRE/TUTOR

Solicito que a mi hijo(a),_____, se le permita tomar el medicamento en la escuela. Asumo plena responsabilidad por el suministro de la medicación y me atengo a la normativa y procedimientos establecidas por el Distrito que figuran al dorso de este documento. Solicito que la escuela cumpla con las órdenes dictadas por el médico cuyo nombre figura en este documento.

Considero que mi hijo(a) se encuentra en un estado físico, mental y de conducta que le permiten asumir la responsabilidad de tomarse el medicamento por sus propios medios. Mediante la presente expresamente eximo al Distrito Escolar Unificado de Los Ángeles de todo derecho o reclamo de cualquier índole que yo pudiera tener en contra del Distrito Escolar Unificado de Los Ángeles, de la Junta de Educación del Distrito Escolar Unificado de Los Ángeles, así como contra sus integrantes, voluntarios, o empleados, que pudiera surgir a consecuencia o en relación con la solicitud presentada.

Otorgo permiso para el intercambio de información con respecto al consumo individual de medicamentos en la escuela entre el médico autorizado y la farmacia.

Nombre del padre/madre/tutor _____ Firma _____ Fecha _____

( ) Teléfono _____ ( ) Teléfono de trabajo _____ ( ) Teléfono de cellular _____

SCHOOL PERSONNEL

I have received the request of the parent/guardian and orders of the above licensed health care provider and believe that the above student is physically, mentally, and behaviorally capable of self-administering this medication at school.

Signature of School Principal _____ Signature of School Nurse _____ Date _____

DIRECTIVAS ESTABLECIDAS POR EL DISTRITO CON RESPECTO AL CONSUMO DE MEDICAMENTOS DURANTE EL HORARIO ESCOLAR

1. Los medicamentos con receta deben estar debidamente etiquetados por una farmacia de los Estados Unidos y deben contener la siguiente información: (conforme con la receta de un médico titulado y debidamente autorizado)

    - ❖ Nombre completo del estudiante
    - ❖ Nombre del médico
    - ❖ Dosis, horarios, medio y forma de administración
    - ❖ Periodo de tiempo en que se ingerirá el medicamento: 1 año o corto período de tiempo (fecha en que el medicamento debe ser descontinuado o número de días que el medicamento debe ser administrado.)
2. Los medicamentos que no requieran receta (es decir, de venta libre al público), que hayan sido autorizados a través de la presente solicitud, podrán ser suministrados en la escuela únicamente si están en su envase original

3. Las solicitudes para el suministro de medicamentos durante el horario escolar deberán renovarse anualmente.

4. En caso de ocurrir un cambio en la medicación del estudiante, en su estado de salud, o en relación al médico autorizado, el padre de familia o tutor legal le notificará a la enfermera escolar o al administrador de la escuela y llenará una nueva solicitud para el suministro de medicamentos durante el horario escolar

5. Los medicamentos inyectables, que se suministren en casos de emergencia, requieren de preparación especial y capacitación del personal escolar a cargo de la enfermera escolar habilitada.

6. Una copia de la presente autorización debe acompañar al medicamento.

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