Medication in School

PIONEER UNION SCHOOL DISTRICT
6862 Mt. Aukum Road, Somerset, CA 95684

PIONEER/WALT TYLER – Phone (530) 620-7210
Fax (530) 620-9509

MOUNTAIN CREEK – Phone (530) 620-4393 option 2
jmonti@pioneeerusd.org

1. ADMINISTRATIVE STATEMENT

Medication may be dispensed to students by designated school personnel whenever a physician finds it necessary to prescribe medication to be taken during the regular school day.

2. MEDICATION PROCEDURE

The form below or similar authorization must be completed by the parent or guardian **AND** physician for any medication that is to be taken during the regular school day. All medication administered at school, even if sold over the counter, must be prescribed by a physician.

The parent/guardian must provide all medication, including over-the-counter medication, in the original container. For prescription medication, the pharmacist can provide a second labeled bottle so that one bottle can be brought to school and one bottle can be left at home.

3. PARENT REQUEST

I request that designated school personnel assist my child by giving him/her the medication as set forth in the physician=s instructions below and give consent for the designated school personnel and physician signing below to exchange medication information. If the medication is an asthma inhaler or an Epi pen, I consent to my child self-administering the medication if designated to do so by the physician below. I release the district and school personnel from civil liability in the event my child has an adverse reaction to the asthma inhaler or Epi Pen. I may terminate consent for administration of medicine at any time.

Student's Name: _____ Birth Date: _____ Grade:

Parent's Signature: X _____ Date: _____

4. PHYSICIAN=S INSTRUCTIONS

MEDICATION	DOSE	METHOD OF ADMINISTRATION	HOW OFTEN (e.g., EVERY 4 HRS)	DURATION (e.g., SCHOOL YEAR)
#1				
#2				

Indication for Medication: #1 _____ #2 _____

Special Instructions/Precautions: #1 _____ #2 _____

This student is able to carry and self-administer his/her asthma inhaler ___Yes ___No
This student is able to carry and self-administer his/her Epi Pen ___Yes ___No

Physician Signature: X _____ Date: _____

Physician Name (PRINT): _____ Phone: _____

BASIC LEGAL PROVISION: 49423. Notwithstanding the provision of Section 49422, 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.

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PIONEER UNION SCHOOL DISTRICT

Asthma Form

Please indicate the appropriate responses below.
It will be assumed that incomplete or unmarked directions do not apply to this student.

My patient, _____, has O mild O moderate O severe asthma and should
Print Name
participate in a O regular O modified physical education program.

This patient should use an inhaler O albuterol O cromolyn O metaproterenol O terbutaline O other _____

approximately _____ minutes before P.E. class.

If symptoms of asthma occur during exercise, this patient should use _____ puffs of his/her inhaler and repeat this dose every ____ hours.

PLEASE INITIAL ONE OF THE FOLLOWING RESTRICTIONS

_____ This patient may participate in all activities, including running, but occasionally may become symptomatic and may need to slow down or stop.

_____ This patient should run no further than _____ or no longer than _____ minutes.

_____ This patient may run in short bursts only with rest in between (as in field games, basketball, or tennis).

_____ This patient may **not** run in P.E. this semester, but may walk.

_____ This patient may **not** run in P.E. this school year, but may walk.

The following modifications should be made: _____

_____

Comments: _____

_____

_____

DOCTOR'S SIGNATURE	DATE	PHONE NUMBER
PRINT DOCTOR'S NAME		

My child's teacher has my permission, if necessary, to call the above doctor in order to seek clarification.

PARENT'S SIGNATURE	DATE	PHONE NUMBER
PRINT PARENT'S NAME		

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