Medication at School Form

To be renewed annually (at least once each school year) and
whenever changes in medication or authorized health care provider occur.

Student Name: ____ Date of Birth: _______________
Last First M.I.

Student ID#: ____________ School: _____________________________ Grade/Room #: ______/________

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Diagnosis or Reason for Medication during the school day: ______________________________________

If Rx is for an EMERGENCY SEIZURE MED – Do not list here. Please use reverse (or pg 2) of this form.

Name of Medication	***Dose and Frequency***	***Route***	***Time(s) to be given at school***
			______________________
			______________________
			______________________

Possible **side effects** or other serious considerations regarding medication(s): ____________________________________

FOR **AUTO-INJECTOR EPINEPHRINE (EpiPen):**

Student is allergic to: ____ Student
may carry EpiPen and self-administer Yes No (If yes, check statement below)

FOR **ASTHMA INHALERS**:

Student **may** carry asthma inhaler and self-administer Yes No (If yes, check statement below)
Does student need the prescribed medication ___________ minutes before physical activity or sports? Yes No

☐ ***I have instructed the student in the proper method to use his/her asthma inhaler and/or EpiPen and in my opinion the student is competent to safely self-administer the medication at school.***

____ **Date:** _____________________
Health Care Provider Signature

____ **Phone:** _____________________
Health Care Provider Name / Address (Please Print)

PARENT REQUEST AND AUTHORIZATION:

I request that the school nurse or designated school personnel assist my child with medication as ordered by the health care provider. I give permission for the school nurse to communicate with the health care provider on matters related to this medication. I will notify the school nurse of any changes in medication, health status, or authorized health care provider and will provide a new medication order form. I understand I may submit a written statement to withdraw my consent for administration of medication at school at any time.

I understand that the school must receive the medication in a container with a pharmacy label that indicates name of student, health care provider's name, medication, dose, route, and time to administer (over-the-counter medication must be in the original container). I understand that the medication must be delivered to the school by the parent, guardian, or adult designee.

I understand that my child may only take medication at school (including over-the-counter) if the school has received ALL of the following: a) Current California-authorized health care provider order, b) Parent/ guardian signature, and c) Properly labeled medication.

Parent Statement for Emergency Seizure Medications: I understand emergency seizure medication at school may only be administered by licensed health professionals, parent, or parent designee according to state laws and regulations.

1. I will notify the school nurse if the emergency seizure medication was administered to my child within 12 hours of child attending school.
2. I will notify the school nurse with any change in my child's seizure activity.

3. I will notify the school nurse at least 2 weeks in advance if my child will be attending a field trip, including overnight camp or trip. I understand physician clearance or new medication order may be required.
4. I will maintain current phone numbers with school nurse and school office in case 911 is called.
5. I will provide the necessary medication, supplies, and equipment.

PARENT/GUARDIAN SIGNATURE: ____ **DATE:** _____________

Physician Authorization

Seizure Management at School

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER for School Hours Only

☐ **No Seizure Medication at School**: Since child has not had a seizure requiring medication in the past 6 months, no emergency seizure medication is required at school. **Call 911** if child has:

- ✓ Convulsive seizure lasting more than _________ minutes.
- ✓ Repeated seizures without regaining consciousness.
- ✓ More seizures than usual or change in type of seizure.

PRN Seizure medication required if:

☐ **Recurrent Brief Seizures**: If the child has repeated, brief seizures, with complete recovery between the seizures, and the child has more than _____ **seizures in** _____ **hours,**

☐ **Call 911** with seizure onset

☐ **Non-Convulsive Seizures**: If the child has a nonconvulsive seizure (with or without loss of consciousness) lasting longer than 10 minutes,

☐ **Call 911** with seizure onset

☐ **Prolonged Convulsions**: If the child has a convulsive seizure, with body stiffness or jerking, and loss of consciousness, **lasting longer than _____ minutes,**

☐ **Call 911** with seizure onset

☐ **Medicate with:**

______ mg. lorazepam buccal administration.

______ mg. Diastat rectal administration.

______ ml. midazolam (______mg/______ml).
Give _____ spray(s) each nostril.

☐ If seizure continues after 10 minutes, repeat above dose and **Call 911.**

Maximum dose is 2 doses in 12 hours

☐ **Student must be cleared by Physician to participate in Sports or Overnight Camp.**

Plan For Emergency Care When Licensed Nurse Is Not on Campus

For a Seizure lasting _____ minutes, Call 911 when a licensed nurse is not available on campus and during any of the following activities:

- ✓ **Licensed Nurse (RN or LVN):** May be temporarily off campus for 30 minute lunch; Staff Meeting; or Emergency at nearby school. If student is without seizures requiring treatment for 6 months RN/LVN may not be assigned to this campus daily but would respond from neighboring school.
- ✓ **School Bus**: Student may ride Bus.
- ✓ **Exercise and Sports**: Activity Restrictions: if student is operating equipment or swimming, he/she needs a 1:1 spotter.
- ✓ **Extracurricular Activities**: including field trip, overnight camp/trip.
- ✓ **Disaster**: In the event of a Public Disaster or Epidemic, Unlicensed Assistive Personnel are to be trained to administer the medication as authorized by Health Care Provider and Parent/Guardian.

AUTHORIZED HEALTH CARE PROVIDER SIGNATURE

Health Care Provider Authorization: My signature below provides authorization for the above written orders. I understand that all procedures and administration of medication will be implemented in accordance with state laws and regulations. This authorization is for a maximum of one calendar year.

Health Care Provider (please print): ______________________________ Signature: ___________________________

Phone #: ____ Date: _______________________________

California Education Code, Section 49423 defines 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."**