REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Please fax or return form to the School Health Office

Student: _____**Birth Date:** _____ **Male** ☐ **Female** ☐

School: _____ **Teacher:** _____**Grade:** _____

School FAX: _____ **School Phone:** _____

TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER

(Make copies if more than one medication is required)

Medication Name: _____Strength (mg, ml, mcg):_____

Dose (3 of tab, puffs, etc.): _____ Method of Administration: _____

Time of Administration: _____

Start: Immediately_____ Other Date_____ Stop_____ End of Year _____ Other Date/Duration_____

PRN (prescribed as needed): Symptoms_____

Reason for Medication: _____

Restrictions and/or important side effects: _____ None Anticipated_____ Yes, please describe_____

REQUEST FOR SELF-ADMINISTRATION OF INHALER AND EPI-PENS
AND/OR ANY OTHER HEALTH RELATED MEDICATION(S)

This student is both capable and responsible for self-administering auto-injectable epinephrine, inhaled asthma medication and/or any other health related medications:

_____Yes, unsupervised. _____Yes, supervised. _____ No, (to be administered by trained staff)

Health Care Provider's Name: _____

Health Care Provider's Signature: _____Date: _____

Phone #: _____ Fax #: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

PARENT/GUARDIAN CONSENT FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

Parent(s) /guardian(s) of _____ request that medication be administered by the school nurse or a member of the school staff if the school nurse is not available. I consent to allow disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel. I will notify the school if the medication has changed or is no longer needed. Medication will be furnished in its pharmacy-labeled container.

Parent/Guardian Signature: _____ **Date:** _____ **Phone#:** _____

PARENT/GUARDIAN CONSENT FOR SELF-ADMINISTRATION OF MEDICATION
FOR AUTO-INJECTABLE EPINEPHRINE OR INHALED ASTHMA MEDICATION OR OTHER HEALTH RELATED MEDICATIONS

I hereby consent for my child, _____, to self-administer the following medication during the regular school day or when attending school-related activities: ☐ **Auto-injectable epinephrine** ☐ **Inhaled asthma medication**

I also consent to disclose identifiable health information by the health care provider to the school nurse or other personnel designated by Ceres Unified School District

I acknowledge that I have an obligation to notify the school if my child's medication, dosage, frequency of administration or reason for administration changes during the school year.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to indemnify and hold harmless, release and covenant not to sue the District, it's officers, employees, and agents, for any and all liability, claim or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self-administration of medication.

Parent/Guardian Signature_____ **Date:** _____**Phone#:** _____

School Nurse Signature: _____ **Date:** _____

PETICION PARA LA ADMINISTRACION DE MEDICAMENTO EN LA ESCUELA

Por favor enviar por fax o regresarlo a la oficina escolar

Estudiante: _____ **Fecha de Nacimiento:** _____ **Masculino** □ **Femenino** □

Escuela: _____ **Maestro/a:** _____**Grado:** _____

Fax de Escuela: _____ **Teléfono de Escuela:** _____

TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER

(Make copies if more than one medication is required)

Medication Name: _____Strength (mg, ml, mcg):_____

Dose (3 of tab, puffs, etc.): _____ Method of Administration: _____

Time of Administration: _____

Start: Immediately_____ Other Date_____ Stop_____ End of Year _____ Other Date/Duration_____

PRN (prescribed as needed): Symptoms_____

Reason for Medication: _____

Restrictions and/or important side effects: _____ None Anticipated_____ Yes, please describe_____

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AND/OR ANY OTHER HEALTH RELATED MEDICATION(S)

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_____Yes, unsupervised. _____Yes, supervised. _____ No, (To be administered by trained staff)

Health Care Provider's Name: _____

Health Care Provider's Signature: _____Date: _____

Fax #: _____ Phone #: _____

DEBE SER COMPLETADO POR EL PADRE O TUTOR

CONSENTIMIENTO DE PADRE/TUTOR PARA ADMINISTRACION DE MEDICAMENTO POR EL PERSONAL ESCOLAR

Yo/Nosotros, padre(s) o tutor(es) de _____solicitamos que la medicina será administrada por la enfermera de la escuela o por un miembro del personal escolar si la enfermera de la escuela no está disponible. Doy mi consentimiento para permitir la divulgación de información de salud identificable del proveedor de servicios de salud a la enfermera de la escuela u otro personal escolar designado. Notificare a la escuela si el medicamento ha cambiado o si ya no es necesario. La medicación se entregará en su envase con la farmacia marcado.

Firma del padre/tutor: _____ **Fecha:** _____ **Teléfono:** _____

CONSENTIMIENTO DE PADRE/TUTOR PARA LA AUTO-ADMINISTRACIÓN DE MEDICAMENTO
PARA EPINEFRINA AUTO-INYECTABLE O MEDICAMENTO DE ASMA INHALADA U OTRO MEDICAMENTO

Doy mi consentimiento para que mi hijo, _____, se auto-administre el siguiente medicamento durante el día escolar o cuando asiste actividades relacionadas con la escuela: □ Epinefrina Auto-Inyectable □ Medicamento de asma inhalada

Doy mi consentimiento para revelar información de salud identificable por el proveedor de cuidado de salud a la enfermera de la escuela u otro personal designado por el Distrito Escolar Unificado de Ceres.

Reconozco que tengo la obligación de notificar a la escuela si la medicación de mi hijo, la dosis, la frecuencia de administración cambia o la razón de los cambios de administración durante el año escolar.

Yo, en nombre de mí mismo, mi hijo, nuestros herederos, albaceas y cesionarios, por lo presente estoy de acuerdo en indemnizar y liberar de responsabilidad, la liberación y pacto de no demandar al Distrito, sus funcionarios, empleados y agentes, de cualquier y toda responsabilidad, reclamación o causa de acción de cualquier naturaleza, incluyendo pero no limitado a la lesiones personales o la muerte, la que puede ser el resultado de la auto-administración de medicamento de mi hijo.

Firma del padre/tutor: _____ **Fecha:** _____ **Teléfono:** _____

School Nurse Signature: _____ **Date:** _____