**OAKDALE JOINT UNIFIED SCHOOL DISTRICT**

STUDENT PICTURE HERE

 **District Office 168 South 3rd Avenue (209) 848-4884 Fax: (209) 847-0155**

**Request for Medication Administration During School Hours**

**(Spanish)**

Approved by School Nurse: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Student: ­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER CALIFORNIA CODE OF REGULATIONS TITLE 5, SECTION 601(A)** |
| ***\*****Self-Administration* ***ONLY*** *for Auto-Injectable Epinephrine, Inhaled Medication, and Diabetes Medication*  |
| **DX/REASON** | **MEDICATION** | **DOSE** | **ROUTE** | **TIME** | **SIDE EFFECTS** | **For as needed meds, symptoms allowing administration** | **To be kept in the health office** | **\*Student may self-carry and self-administer** |
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|  If indicated (checked) above, I give permission for the above student to carry and self-administer medication. I have confirmed that the student is capable of appropriate self-administration. If the student is younger than 18, the parent/guardian assumes all liability related to this student’s use, timing and technique in self-administering this medication. Other medication(s) will be kept and administered accordingly.  I understand that specialized physical health care services may be performed by unlicensed/non-medical designated school personnel under the training and supervision provided by the school nurse or other health care professional.Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Name: (Please Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Stamp Here |

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| **DEBE SER LLENADO POR UN PADRE/GUARDIÁN** |
|  Yo pido que a mi niño se le permita tomar medicamentos durante las horas de escuela de acuerdo a las instrucciones del Doctor del niño. Yo entiendo es mi responsabilidad **traer los medicamentos en su envase original provisto por la farmacia, con el rotulo que contenga el nombre del niño, el nombre del medicamento, la dosis, y las instrucciones** (Código Educacional 49423) y de notificarle a la escuela si hay un cambio de medicamentos o si el niño ya no la necesita. Yo le doy autorización al personal de escuela de asistir con este medicamentos (Código Educacional Sección 49423 y 49480). Doy mi consentimiento para el intercambio de información entre el doctor y/o el farmacólogo y la enfermera de la escuela o su designado para asegurar la administración segura del medicamento(s) incluido(s) en la lista su doctor. **Yo entiendo esta forma debe ser puesta al día cada año y también cuando cambie la receta.** Yo entiendo que desechara los medicamentos que no se recojan una semana después del terminar el año escolar. Firma del Padre/Guardián: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Números de teléfono durante el día: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_y\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| STUDENT CONTRACT FOR CARRYING OWN MEDICATION: I­­­­­­ ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_will be responsible for carrying, administering, and keeping safe at all times, my medication. I will use the medication in the way prescribed by my physician. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing.  |