TORRANCE UNIFIED SCHOOL DISTRICT

School: Arlington E.S. **Health Office:** (310) 533-4510 x2382 **Fax:** (310) 972-6387

AUTHORIZATIONS for MEDICATION at SCHOOL

TO BE COMPLETED BY PARENT:

Last Name of Pupil, First Name _____ Grade _____ Sex _____ Date of Birth _____ School _____

The above named pupil is required to take medication prescribed by an authorized health care provider during the regular school day. I request that designated School District personnel assist my child in taking the medication in accordance with the instructions provided below by the physician. I authorize the District to communicate with the physician regarding my child's medical condition and/or the medication prescribed for it. I have read and understand TUSD policy regarding medications at school as stated on the back of this form.

Date _____ Telephone Number(s) _____ Parent/Guardian Signature _____

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER:

Name of Medication and Dose Form (tablet, liquid, drops, etc.) _____ Dose _____ Route _____

Time Scheduled at School **OR** Frequency (for as needed medications) _____ Duration of Treatment _____

Purpose of Medication: _____

DESCRIBE SPECIFIC SYMPTOMS, PRECAUTIONS, SPECIAL INSTRUCTION, POSSIBLE ADVERSE SIDE EFFECTS, OR OTHER COMMNETS (PLEASE INCLUDE STORAGE INSTRUCTIONS):

_____

THERE MAY BE CIRCUMSTANCES WHERE IT IS IMPORTANT FOR THE STUDENT TO HAVE THE MEDICATION ON THEIR PERSON:

☐ Yes, student to carry his/her inhaler on campus. I agree that the student is capable of self-administration and is able to manage this medication responsibly.

☐ Yes, also keep a backup inhaler in the health office.

☐ No, health office is best location, student requires supervision.

The pupil, for whom this medication is prescribed, is under my care.

Physician's Stamp _____ Signature of Physician _____

Address _____ Telephone _____ Date _____

TO BE COMPLETED BY SCHOOL STAFF UPON RECIEPT OF MEDICATION:

- Medication received matches physician's order (name, dose form, dosage, unopened for OTC) _____
- Quantity initially received _____

Parent/Guardian Signature _____ Date _____ Staff Signature _____ Date _____

TO BE COMPLETED BY SCHOOL STAFF UPON PICK UP OF UNUSED MEDICATION:

- Quantity picked up _____

Parent/Guardian Signature _____ Date _____ Staff Signature _____ Date _____

AUTHORIZATION for MEDICATION at SCHOOL

The purpose of allowing medications to be taken by pupils at school is to help provide for their general welfare by following instruction of their physician. It shall be the school responsibility to provide reasonable and prudent supervision while the pupil takes the medication. It shall be the pupil's (parent's) responsibility to take the prescribed medication in accordance with their physician's instructions.

Authorized Health Care Provider means an individual who is licensed by the State of California to prescribe or order medication, including, but not limited to, physician or physician assistant. (AR 5141.21)

Medication may include not only a substance dispensed in the United States by prescription, but also a substance that does not require a prescription, such as over-the-counter remedies, nutritional supplements, and herbal remedies. (AR 5141.21)

Policy Regarding Medication at School

According to California State Education Code 49423, specific procedures must be followed with regard to taking medications at school.

During the regular school day, any pupil who is required to take mediation prescribed by a physician must provide the following every school year:

1. A written statement from the physician stating the medication, dose form, dosage, route of administration, purpose of medication and time in which medication is to be taken as well as special instructions or relevant side effects.
2. A written statement from the parent/guardian of the pupil granting their permission that the physician's order be carried out.
3. For prescription medication: the medication must be in a labeled pharmacy container, labeled by a California pharmacist giving the student name, doctor name, medication, dose form, dosage, route of administration, and schedule. For over the counter medication: the medication must be in the original unopened container.

All medication is to be kept in the health office, unless they physician's order states that the life sustaining medication is to be carried by the student. It is the student's responsibility to come to the office to take the prescribed medication at the designated time.

A parent/guardian can bring medication to the school office and give to their student directly without a physician's order.

This policy is for the protection of all students.

NOTICE – PLEASE READ BEFORE SIGNING REQUEST

A District Nurse or Health Assistant is not present at the school site at all times or on all days when school is in session. Therefore, because assistance may be provided by nonmedical District personnel, parents must assure that the physician provides complete, precise, legible, directions and instructions. The District is not responsible for notifying parents before or after prescribed medication is depleted or the expiration occurs. Expired medications will not be administered. This request for District assistance expires at the end of the school year in which it is made.

THIS REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR IN WHICH MADE.