Temple Beth Sholom

Parent Notification for the Administration of Medicine at School

(Please attach photo of your student here)

Name of Student:_____

To the Parent/Guardian:

Medical treatment is the responsibility of the parent/guardian and an authorized care provider. An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter**, may be given at school when it is deemed absolutely necessary by the authorized health care provider that the medication be given during school hours **The parent/guardian is urged, with the help of your child's authorized health care provider, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out an authorized health care providers written orders. Designated non-medical school personnel may be assisting with your child's medication. Medication will be safely stored and locked or refrigerated, if required.

Emergency medicine such as EpiPens or inhalers may be carried by the student **when recommended by an authorized health care provider and parent**. Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING CONDITIONS MUST BE MET:

1. A written statement signed by the licensed authorized health care provider/dentist specifying the reason for the medication, the name, dosage, time, routes, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. If pill splitting is required to obtain the correct dose of medication to be administered, only pills that are scored may be split, scored pills may be split in half only, and a commercial pill splitting device should be used for correct splitting.
7. Over the counter medication that has been prescribed by an authorized health care provider must be in its original container.
8. A separate form is required for each medication.

Note: Whenever there is a change in medication, dosage, time or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider's instructions with your child , so that he/she is aware of the time medication is due at school.

This request is valid until May 2016 – Please complete both sides of this form

Temple Beth Sholom
PARENT/GUARDIAN AN AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student:_____

Birthdate:_____Grade:_____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION PRESCRIPTION AND NONPRESCRIPTION.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider.

Emergency medicine such as EpiPens or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release Temple Beth Sholom from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature:_____Date:_____

Cell Phone:_____Home Phone:_____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication:_____

Medication:_____Dose:_____Route:_____Time:_____

If PRN:Amount of time between doses:_____Maximum Number of doses:_____per day.

Possible medication reactions:_____

Instruction for emergency care:_____

Authorized Health Care Provider Signature:_____

Authorized Health Care Provider Name (print clearly):_____

Telephone:_____

Date of Request:_____

Date to Discontinue Medication:_____

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instruction in, and demonstrates an understanding of proper usage.

Health Care Provider Initials_____

School Use:
Reviewed by: _____Date:_____

This request is valid until May 2016 – Please complete both sides of this form