ONTARIO-MONTCLAIR SCHOOL DISTRICT

Health Services

PHYSICIAN INSTRUCTIONS

For SCHOOL ASSISTED MEDICATION

School Phone # _____

School Fax # _____

A. This form must be completed before any medication *(prescription or over-the-counter)* can be given, or taken, at school.
Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.

Student Name: _____ **Date of Birth:** _____

PHYSICIAN USE ONLY

1. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** _____ **Stop Date:** _____

☐ **If DAILY ~ Time(s) to be given:** _____

☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** _____

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

2. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** _____ **Stop Date:** _____

☐ **If DAILY ~ Time(s) to be given:** _____

☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** _____

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

Physician Signature: _____ ***Date:*** _____

Physician Name: _____ **NPI #** _____

Address: _____ **Phone:** _____

City: _____ **Zip:** _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

California Education Code section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for him 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 such 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 matters set forth in the physician's statement.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

☐ **OMSD RN Verified** _____ **Date:** _____

ONTARIO-MONTCLAIR SCHOOL DISTRICT

Health Services

Parent Request

For Assistance with Medication at School

B. The parent or guardian must complete this page before any medication *(prescription or over-the-counter)* can be given, or taken, at school.
Signature of parent or guardian is required. This form must be renewed each school year or with any change in medication.

Student Name: _____ **Date of Birth:** _____

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

A. **I hereby request that the staff of my child's school assist in giving medication** to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed and concurrently give permission for school to bill Medi-Cal and /or any medical insurance for medical services rendered at the school site.

Parent or Guardian Signature: _____ ***Date:*** _____ **Phone Number:** _____

B. **For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR SELF-CARRY requests only**: I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication.* I also give permission to contact the physician for consultation and exchange of information as needed.
Student agrees never to share epi-pen/inhaler with another student.
For Asthma Medication: Student agrees that after two puffs, if there is not marked improvement, he/she will go to the health office.
It is advisable that a spare inhaler be kept in the health office.
For Epi-pen: If student self-administers epi-pen, he/she will immediately have someone notify health office staff.
It is advisable that a spare epi-pen be kept in the health office.

Parent or Guardian Signature: _____ ***Date:*** _____ **Phone Number:** _____

With the parent or guardian signature to allow his or her child to self-administer either inhaled asthma medication or auto-injectable epinephrine at school, the district and school personnel are released from all civil liability as a result of any complications that may arise.

Student Contract – Epi-pens/Asthma Inhalers Only

I agree to keep my medication in a safe and secure place, such as on my person, at all times. I agree I will NEVER share my medication with another student. If I am using my inhaler more than once a day, or several times a week, I will speak with the school nurse. If I self-administer my Epi-pen I will immediately have someone notify health office staff.

Student Signature: _____ ***Date:*** _____

Parent Signature: _____ ***Date:*** _____
All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

☐ **OMSD RN Verified** _____ **Date:** _____

DISTRITO ESCOLAR DE ONTARIO-MONTCLAIR

Servicios de Salud

INDICACIONES MÉDICAS

Para que la ESCUELA SUMINISTRE MEDICAMENTOS

Número de teléfono escolar _____

Número de fax escolar _____

A. Este formulario debe completarse antes de suministrar cualquier medicamento, llevarlo o tomarlo en la escuela (prescripciones o medicinas de los mostradores farmacéuticos).
Son necesarias las firmas del médico y de los padres. Este formulario debe ser renovado anualmente o si ocurre cualquier cambio en los medicamentos.

Nombre del estudiante: _____ **Fecha de nacimiento:** _____

Lo siguiente debe llenarlo y firmarlo solamente el médico

PHYSICIAN USE ONLY

1. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** _____ **Stop Date:** _____

☐ **If DAILY ~ Time(s) to be given:** _____

☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** _____

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

2. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** _____ **Stop Date:** _____

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☐ **If AS NEEDED (prn) ~ Frequency:** ☐ **Every 3 to 4 hrs.,** ☐ **Every 4 to 6 hrs.,** ☐ **Other :** _____

☐ ***Self carry – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
- (**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

Physician Signature: _____ ***Date:*** _____

Physician Name: _____ **NPI #** _____

Address: _____ **Phone:** _____

City: _____ **Zip:** _____

Todas las medicinas serán automáticamente descontinuadas al terminar el ciclo escolar. Los medicamentos nuevos deben comenzar con el ciclo escolar.

El Código de Educación de California estipula en la Sección 49423 que el alumno que necesita tomar medicina durante el día escolar, debe ser descrita por un médico, puede suministrarse por la enfermera o el personal escolar designado del distrito y deben recibir (1) declaración escrita por su médico detallando el método, cantidad y horario en que tal medicina debe suministrarse (2) declaración escrita de padre, madre o tutor del alumno indicando el deseo de que el personal del distrito escolar ayude al alumno a actuar con las indicaciones del médico.

*El Código de Educación de California 49423 (c) estipula; Un alumno está sujeto a acción disciplinaria de acuerdo a la sección 48900 si hace uso de inhaladores e epinephrine inyectable de una manera en la que no se ha descrito.

☐ **OMSD RN Verified** _____ **Date:** _____

DISTRITO ESCOLAR DE ONTARIO-MONTCLAIR

Servicios de Salud

INDICACIONES MÉDICAS

Para que la ESCUELA SUMINISTRE MEDICAMENTOS

B. Este formulario debe completarse antes de suministrar cualquier medicamento, llevarlo o tomarlo en la escuela (prescripciones o medicinas de los mostradores farmacéuticos).

Son necesarias las firmas del médico y de los padres. Este formulario debe ser renovado anualmente o si ocurre cualquier cambio en los medicamentos.

Nombre del estudiante: _____ **Fecha de nacimiento:** _____

Los padres piden que se suministren los medicamentos en el plantel escolar

Yo, entiendo que las normas del distrito escolar estipulan que las medicinas se mantengan en un lugar seguro, bajo la supervisión de un adulto empleado del distrito escolar y que el estudiante o persona no debe tenerla en su posesión (con la excepción de inhaladores e epinephrine inyectable acompañado de la prescripción e indicaciones del médico.

C. **Yo, por este medio pido que el personal ayude a mi hijo proporcionado su medicamento** durante horas escolares de acuerdo a lo estipulado por el médico. Yo, autorizo a que se comuniquen con mi médico y si es necesario, obtengan toda la información médica y en conjunto autorizo que las autoridades escolares pasen la nota a Medi-Cal ó a mi seguro medico por los servicios médicos dados en la escuela.

Firma de padres o tutores: _____ ***Fecha:*** _____ **Teléfono:** _____

D. **Petición para que el alumno tenga en su posesión su INHALADORPARA EL ASMA O INYECCIÓN EPINEPHRINE**: Yo, por medio de la presente, solicito que mi hijo pueda traer consigo su inhalador para el asma o su inyección epinephrine. Yo, entiendo que si mi estudiante no obedece las normas y responsabilidades al traer su medicamento, perderá el privilegio de traerlo consigo.* También, doy mi autorización para que se comuniquen con el médico si necesitan información.

El estudiente no compartira su pluma de Epipen/inhalador con otro estudiante.
Para medicamento de Asma: El estudiante esta de acuerdo, que si no hay mejoramiento despues de dos descargas, El o' Ella se reportara a la oficina de salud.
Es aconsejable de tener un extra inhalador en la oficina de salud.
Para medicamento de Epipen: Si el estudiante se autoadministra el Epipen, El o' Ella hará que alguien notifique a la oficina de salud.
Es aconsejable que se tenga una extra pluma de Epipen en la oficina de salud.

Firma de padres o tutores: _____ ***Fecha*** _____ **Teléfono:** _____

Contrato con el estudiante – EpiPens/Solamente estudiantes con inhaladores

Yo estoy de acuerdo en que mantendré mi medicamento en un lugar seguro y conmigo en todo momento. Yo, estoy de acuerdo en que NUNCA compartiré mi medicamento con ningún estudiante. Si uso mi inhalador más de una vez por día o varias veces a la semana, hablaré con la enfermera escolar. Si me auto administro mi Epipen, inmediatamente tendré a alguien que notifique al personal de la oficina de salud.

Firma del estudiante: _____ ***Fecha:*** _____

Firma de los padres o tutores: _____ ***Fecha:*** _____

Todas las medicinas serán automáticamente descontinuadas al terminar el ciclo escolar. Los medicamentos nuevos deben comenzar con el ciclo escolar.

*El Código de Educación de California 49423 (c) estipula; Un alumno está sujeto a acción disciplinaria de acuerdo a la sección 48900 si hace uso de inhaladores e epinephrine inyectable de una manera en la que no se ha descrito.

☐ **OMSD RN Verified** _____ **Date:** _____