Point Arena Joint Union High School District
Arena Union Elementary School District
P.O. Box 87, Point Arena CA 95468
(707)882-2803 * Fax (707)882-2848

Brent Cushenbery, Superintendent
Catherine Chin, Fiscal Resources – Eloisa Oropeza, Human Resources

ADMINISTERING MEDICATION AND MONITORING HEALTH CARE

Dear Parent/Guardian,

California State Law governs the giving of medication to students in school. Whenever possible, please attempt to schedule medications so they do not need to be administered during school hours. In compliance with this law, when your child needs to receive ANY medication at school (even non-prescription, "over the counter" medications) it may be given if ALL of the following guidelines are met.

The parent/guardian must:

1. Obtain a medication form from the office to be completed by yourself and the health care provider.

2. BRING (do not send it with student) the medication to school in the container that was provided by the pharmacy, with its label intact. If the child needs the medication at home also, ask the pharmacist for two separate containers. Label must include:

   a. Student's name
   b. Name of Medication
   c. Amount, dosage and frequency
   d. Name of prescribing provider
   e. Duration of administration
   f. Expiration date

3. Over the counter medication is to be sent in the original container, with the student's name firmly attached.

4. Students are not allowed to transport medications to and from school. A responsible adult must transport the medication.

Students who need medication for emergency use, such as asthma inhalers, insulin and allergy kits, and self-administer such medication, must have approval by their health care provider, parent/guardian, and the school nurse. The student must also sign a pledge of responsibility.

It is the student's responsibility to request the medication at the required time. Thank you for your cooperation with our efforts to provide a safe environment for your child. These guidelines are written to comply with State Law. If you have any questions, please call me at 882-2131.

Sincerely,

Vivian White, RN, PHN, MSN
School Nurse

AUTHORIZATION FOR STAFF TO ASSIST STUDENT WITH ADMINISTRATION OF MEDICATION
(A separate form must be completed by physician for each medication)

Student Name: _____

Date of Birth: _____ School Year: _____

Physician's Authorization of Medication

Name of Medication:	
Dosage:	
Time and Route:	
Side Effects:	
Reason for Medication:	
Conditions Under Which Medication Is To Be Used:	

Physician Name: (please print)	
Physician Signature:	
Date Signed:	
Physician Address:	
Physician Phone:	

IMPORTANT NOTE**: All medication must be in the container in which it was purchased with the pharmacy label that includes dosage, instructions, and the prescribing physician's name. The medication must be prescribed for the student to whom it will be administered.* ***No medications (including over-the-counter medications) will be given at school without a current prescription from a physician.

Parent/Guardian Authorization for Staff to Assist Student with Self-Administration of Medication

I am the legal guardian for the above-named student. I give permission for an authorized staff member of Point Arena Schools District to assist my child with the self-administration of medication as indicated on this form by my child's physician. I give permission for the school administrator, agency nurse, or other designated personnel to consult with the above-named physician regarding any questions about this Authorization.

I understand that it is my responsibility to provide Point Arena Schools District with all necessary medication, supplies and equipment that are needed in order for the student to receive the required medication. I also agree to provide written notification to the school nurse, other duly qualified supervisor of health, or site administrator if there is a change in the student's medication (i.e., change in dosage, frequency, type of medication), health status, or authorized health-care provider.

_____ _____
Parent/Guardian's Signature Date

_____
Parent/Guardian's Printed Name

REVIEWED AND APPROVED

School Nurse's Signature_____ Date_____

IMPORTANT: THIS AUTHORIZATION FORM MUST BE DELIVERED IN PERSON BY THE PARENT OR FAXED. TELEPHONED, STUDENT-DELIVERED OR EMAILED AUTHORIZATIONS WILL NOT BE ACCEPTED. ***NO EXCEPTIONS.***

AUTHORIZATION FOR STUDENT INDEPENDENT SELF-ADMINISTRATION OF MEDICATION

(A separate form must be completed by physician for each medication)

Student Name: _____ DOB_____

Physician's Authorization of Medication for child to Self-Administer Medication

The above-named student has my authorization to carry and independently self-administer the following medication. I am requesting that this student be allowed to carry and self-administer this medication due to the life threatening circumstances that could result if this student does not have immediate access to this medication. I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication without school personnel supervision.

Name of Medication:	
Dosage:	
Time and Route:	
Side Effects:	
Reason for Medication:	
Conditions Under Which Medication Is To Be Used:	

Physician Name: (please print)	
Physician Signature:	
Date Signed:	
Physician Address:	
Physician Phone:	

IMPORTANT NOTE**: All medication must be in the container in which it was purchased with the pharmacy label that includes dosage, instructions, and the prescribing physician's name. The medication must be prescribed for the student to whom it will be administered.* ***No medications (including over-the-counter medications) will be given at school without a current prescription from a physician.

Parent/Guardian Authorization for Independent Self-Administration of Medication

I am the legal guardian of the above-named student. I confirm that the student has been instructed by his/her physician on the proper use of this medication and I approve of my son or daughter's independent self-medication as directed on this form. I also approve of Point Arena assisting with the administration of medication, as needed, while at school to him/her as directed by the physician's instructions. I give permission for the school administrator, agency nurse, or other designated school personnel, to consult with the above-named physician regarding any questions about this Authorization. My child has demonstrated to me that he/she understands the proper use of this medication. He/she is physically, mentally and behaviorally capable to assume this responsibility. If he/she has use of an auto-injectable epinephrine, he/she understands that he/she needs to alert any adult that 911 needs to be called. If he/she has used his/her asthma inhaler as prescribed and does not have relief from an asthma attack, he/she is to alert an adult and seek attention from an appropriate on-site first aide responder.

_____ _____
Parent/Guardian's Signature Date

_____
Parent/Guardian's Printed Name

REVIEWED AND APPROVED

_____ _____
School Nurse's Signature Date

Exhibit Adopted:

ARENA UNION ELEMENTARY/POINT ARENA JT. UHSD
Point Arena, California

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