

**DOWNEY UNIFIED SCHOOL DISTRICT
STUDENT SERVICES
REQUEST FOR ASSISTANCE WITH MEDICATION**

**ONE FORM PER
MEDICATION**

Please check box(s): **DURING REGULAR SCHOOL DAY** **IN THE EVENT OF DISASTER ONLY**

PLEASE READ BOTH SIDES OF THIS FORM BEFORE COMPLETING IT

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

Last Name of Pupil First Name Sex Date of Birth School

The above named pupil is required to take medication prescribed by a physician 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 below regarding my child's medical condition and/or the medication prescribed for it. *If authorized by physician below, I consent to self-administration of Epi-Pen (injectable epinephrine) and release the district and school personnel from civil liability in the event of an adverse reaction to the medication.* **I have read and acknowledge both front and back of this form.**

Date Telephone Signature of Parent/Guardian

TO BE COMPLETED BY A LICENSED PHYSICIAN:

Purpose of Medication Name of Medication

Dosage Prescribed Time Schedule Dose Form (Tablet, Liquid, etc.)

Date of Prescription Length of Time this Medication Will Be Necessary

Precise Method of Administering Medication: _____

DESCRIBE PRECAUTIONS, SPECIAL INSTRUCTIONS, POSSIBLE ADVERSE SIDE EFFECTS, OR OTHER COMMENTS (PLEASE INCLUDE STORAGE INSTRUCTIONS):

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

EPI-PEN/INJECTABLE EPINEPHRINE (IF PRESCRIBED): I verify this student has been instructed in proper administration technique and usage of Epi-Pen/Injectable Epinephrine and as the prescribing physician I request the student to carry this medication on his/her person while at school. _____
Signature of Physician

Print Name of Physician Signature of Physician and Stamp

Address Telephone Date

Please Read Reverse Side

PLEASE PROVIDE MEDICATION SUPPLY

IMPORTANT NOTICE TO PARENTS!

UPON THE SIGNED WRITTEN REQUEST OF A PARENT OR LEGAL GUARDIAN, DISTRICT PERSONNEL MAY ASSIST PUPILS TO TAKE PRESCRIBED MEDICATIONS DURING THE REGULAR SCHOOL DAY ONLY UNDER ALL OF THE FOLLOWING CONDITIONS:

1. The parent or legal guardian of the child requests that during school hours District personnel assist the pupil in taking medication, which is prescribed by a licensed physician. The request must be filed with the school site administrator or school nurse.
2. The prescribing physician completes a signed statement which details the method, dosage amount, dose form and time schedules by which such medication is to be taken as well as the name of the medication, purpose of the medication, prescription date and expiration date (of medication), and length of time medication will be necessary.
3. The parent or legal guardian of the pupil consents in writing to contact the prescribing physician relevant to the medical condition or medication and instructs the physician to answer any questions posed by District personnel regarding the medical condition or the medication prescribed for it.
4. The parent or legal guardian is solely responsible for supplying all medication with which assistance is requested:
 - a. No prescribed medications may be brought to school by pupils.
 - b. Parents or guardians shall deliver or cause to be delivered by an adult or an authorized employee of a pharmaceutical supplier, any prescribed medications to be administered under the provisions of this policy.
 - c. Each medication must be in a separate container which clearly identifies the number of pills, capsules, or dosages contained therein.
5. Whenever possible the parent or legal guardian should come to school to administer the medication.

NOTICE – SELF ADMINISTRATION OF ASTHMA INHALER AND EPINEPHRINE PEN

♥ **Asthma Care Plan must be completed for all students needing Asthma Medication at school** ♥

Should parent and physician authorize self-administration of Asthma inhaler or Epinephrine Pen, the District and school personnel are released from civil liability in the event of an adverse reaction to medication, overuse, improper administration, breakage, loss theft, sharing, playing with or careless storage of medication.

NOTICE - PLEASE READ BEFORE SIGNING REQUEST

A DISTRICT SCHOOL NURSE OR HEALTH CARE ASSISTANT IS NOT PRESENT AT THE SCHOOL SITE AT ALL TIMES OR ON ALL DAYS WHEN SCHOOL IS IN SESSION. THEREFORE, BECAUSE EMERGENCY ASSISTANCE MAY BE PROVIDED BY NON-MEDICALLY TRAINED DISTRICT PERSONNEL, PARENTS MUST ASSURE THAT PHYSICIANS PROVIDE COMPLETE, PRECISE, LEGIBLE DIRECTIONS AND INSTRUCTIONS. THE DISTRICT IS NOT RESPONSIBLE FOR NOTIFYING PARENTS BEFORE OR AFTER PRESCRIBED MEDICATION IS DEPLETED OR THE EXPIRATION DATE OCCURS. THIS REQUEST FOR DISTRICT ASSISTANCE WILL EXPIRE AT THE END OF THE SCHOOL YEAR IN, WHICH IT IS MADE.

SIGNATURE ON FRONT OF PAGE INDICATES THAT I HAVE READ AND FULLY UNDERSTAND THE REQUIREMENTS FOR SCHOOL PERSONNEL ASSISTING WITH THE GIVING OF MEDICATION TO MY STUDENT(S) AT SCHOOL.