Faith Baptist Schools · 7644 Farralone Avenue · Canoga Park, CA 91304 · (818) 340-6131 · Fax (818) 592-0279

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

7:00 AM - 6:00 PM

Authorization expires at the end of the school year or following the summer school session.

(TO BE COMPLETED BY A LICENSED PHYSICIAN)

Student Name: _____ **Birthdate:** ___/___/___
Last First Middle Mo Day Yr

☐ Male ☐ Female **Allergies:** _____ **Age:** _____

Treatment For: _____ **Route:**

Medication Name (generic and trade): _____ ☐ Ear(s) ☐ Oral ☐ Eye(s) ☐ Rectal ☐ Nose ☐ Topical ☐ Other _____

Dose: _____ mg / cc / tsp / drops / puffs **Form:** ☐ Capsule ☐ Ear ☐ Inhaler ☐ Liquid ☐ Nebulizer ☐ Tab ☐ Other _____

Frequency: ☐ ____ Daily ☐ Other _____ ☐ PRN

Date of Prescription: _____ / _____ / 20___ **Length of Time Needed for Medication:** _____
-or- ☐ OTC Mo Day Yr

Adverse Side Effects: _____

Special Recommendations/Comments: _____

This student's medical condition requires immediate use of _____ (medication) and the student's well being is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

The student for whom this medication is prescribed is under my care. x_____ ___/___/20___
Licensed Physician/Surgeon Signature Today's Date

_____ _____ (_____) _____ - _____
Licensed Physician/Surgeon (Print Name) License Number Phone Number

_____ _____ _____ _____
Address City State Zip Code

TO BE COMPLETED BY PARENT/GUARDIAN

I request that my child, _____, be allowed to self-administer the medication at school. I assume full responsibility for supplying all medication and agree to the School's policies and procedures listed on the reverse side. I request that the School comply with the orders of the above licensed health care provider.

I believe that my son/daughter is physically, mentally, and behaviorally capable of self-administering this medication. I hereby expressly waive the release of Faith Baptist Schools and its employees, members, and volunteers from any and all claims of any nature whatsoever I may have against the School arising out of, in connection with, or resulting from the above request.

I give my permission for the exchange of medical information regarding self-administration of medication at school with the authorized health care provider and pharmacist.

_____ x_____ _____/_____/20_____
Parent/Guardian 1 (Print Name) Parent/Guardian 1 Signature Date

(_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
Home Number Cell Number Work Number

_____ x_____ _____/_____/20_____
Parent/Guardian 2 (Print Name) Parent/Guardian 2 Signature Date

(_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
Home Number (if same as above, leave blank) Cell Number Work Number

----------OFFICE USE ONLY----------

☐ Medication Student Self-Carry ☐ Grade Level/Section (Circle One): K3 K4 K5 1 2 3 4 5 6 7___ 8___ 9___ 10___ 11 12
☐ Medication Student Self-Administer ☐ Med Expires: _____/_____/20___
☐ Medication in School Office ☐ Teacher: _____

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PROTOCOL FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

7:00 AM - 6:00 PM

Authorization expires at the end of the school year or following the summer school session.

(TO BE COMPLETED BY STUDENT, PARENT/GUARDIAN, AND LICENSED PHYSICIAN)

Student Name: _____ **Birthdate:** ____/____/____

Last **First** **Middle** **Mo Day Yr**

The student may utilize the prescribed self-administered medication as needed and directed by his/her physician. It is understood that the student has been instructed on the proper use of the prescribed medication. The medication must be properly labeled with the student's name. ***Both the Request for Self-Administration of Medication form and this Protocol*** must be signed by the physician, parent/guardian, and student, then placed on file at the School prior to your child carrying a self-administered medication on his/her person.

Medication: No direct monitoring will be conducted by the school staff. The student is responsible for self-administration of medication as directed by the student's physician.

Inhaler: No direct monitoring will be conducted by the school staff. The student is responsible for self-administration of the inhaler. If the student continues having difficulty breathing, he/she should report to the school office and the parents will be notified by the appropriate school staff.

Self-administered emergency epinephrine: No direct monitoring will be conducted by the school staff. The student is responsible for notifying school staff in the event he/she had the need to self-administer the emergency medication.

- It is the parents' responsibility to immediately notify the school if the child's health status changes, or when a change in physician and/or medication occurs. Changes in procedure must be received in writing from the physician authorizing treatment.
- The district is not responsible for any risk involved with improper handling of this medication including: overuse, improper administration, breakage, theft, loss, sharing, playing with or careless storage of the medication.
- Re-evaluation of the present protocol may be needed if the student is found to display behavior that increases the safety risks of him/her self or the students on campus.

TO BE COMPLETED BY THE PHYSICIAN: The above-named student has been instructed in the proper use of their medication. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the medication at school. He/she is capable of self-administering the medication, understands the purpose, appropriate method, and frequency of use of the medication.

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

PHYSICIAN'S NAME (Print): _____

TO BE COMPLETED BY THE PARENT/GUARDIAN: I permit my child to carry the above-listed medication as ordered by his/her physician. I also specifically release the School and all school personnel from any and all civil liability if my child suffers an adverse reaction as a result of self-administering medication during school hours.

PARENT/GUARDIAN'S SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN'S NAME (Print): _____

TO BE COMPLETED BY THE STUDENT: I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician. I understand that using my medication in a manner other than as prescribed by my doctor can result in disciplinary action taken against me by my School.

✓ **I understand that it is my responsibility to:**

- **Report to the School Office if I need help administering my medication;**
- **Report to the School Office after _____ minutes/hours, if I am not better *after* taking my medication;**
- **Report to the School Office *immediately*, if symptoms worsen.**

STUDENT'S SIGNATURE: _____ **DATE:** _____

STUDENT'S NAME (Print): _____

Please return the fully completed forms to the Administration Office signed by the physician, parent/guardian, and student. Medication forms must be renewed at the beginning of each school year or whenever there is a change in medication or instructions.

NO MEDICATION WILL BE ALLOWED WITHOUT THE REQUIRED SIGNATURES

----------OFFICE USE ONLY----------

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☐ Medication Student Self-Administer ☐ Med Expires: _____/_____/20___ 7___ 8___ 9___ 10___ 11 12

☐ Medication in School Office ☐ Teacher: _____