Chino Valley Unified School District

5130 Riverside Drive, Chino, CA 91710-4130
(909) 628-1201 Health Services Fax: (909) 548-6090

PARENT and PHYSICIAN/ HCP REQUEST for the ADMINISTRATION of MEDICATION rev 5-16

Student JOHN DOE Birthdate 01-01-2001 Grade 9

Address 111 PEYTON DRIVE C.H. 91709 Home Telephone (909)123-4567

School AYALA H.S. SCHOOL FAX: (909) 548-6005 Attn: Health Office

PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION

The law allows any person to assist in carrying out a physician's/HCP recommendation. The school recognizes the desirability of following a physician's/HCP recommendations as nearly as possible at school, just as does a parent at home or any other person (not necessarily a nurse) if the physician/HCP requests assistance. The fact that this is a service or accommodation is recognized by all parties signing this form, and in so signing, agree to hold the District, its officers, employees, or agents harmless from all liability, suits, or claims of whatever nature or kind that might arise out of these arrangements. **I hereby authorize an exchange of information between the school nurse and the physician/HCP listed below regarding the prescribed medication(s). At school/school functions, I request that medication(s) be administered to my child by school staff or field trip/camp staff in accordance with the physician's/HCP written instructions below.**

Parent/Guardian signature Jane Doe **Date** 6-1-17

PHYSICIAN/ HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

1)Medication Tylenol Diagnosis/Reason for medication PAIN

May Substitute Generic: ✓Yes ___No Discontinue Medication at end of school year July 31, 2018 or_____

Dose/How administered 650 mg. PO Time/Frequency/ Repeat in how many hours every 4 hours PRN

Notify physician/HCP for the following side effects: NO IMPROVEMENT

Disposition of pupil following administration of medication: RETURN TO CLASS

2)Medication ALBUTERAL INHALER Diagnosis/Reason for medication ASTHMA

May Substitute Generic: ✓Yes ___No Discontinue Medication at end of school year July 31, 2018 or_____

Dose/How administered 2 Puffs inhaled Time/Frequency/ Repeat in how many hours every 4 hours prn

Notify physician/HCP for the following side effects: Palpitations, Vomiting wheezing, cough, shortness of breath

Disposition of pupil following administration of medication: Return to class

This student is trained to use asthma inhaler/emergency Epinephrine and student may self-administer on campus:

✓**yes** ___**no Parent Signature** Jane Doe ✓**yes** ___**no Physician/HCP Signature** Dr Doe

The above medication(s) may be administered by non-licensed school personnel whenever necessary.

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Physician's/HCP name (printed) James DOE MD

PHYSICIAN/HCP SIGNATURE James Doe

Date 6-1-2017

Address 222 Bandaid Ave

Telephone (909) 111-2222

Fax (909) 333-4444

Physician/HCP Office Stamp

Dr. Doe's stamp
OFFICE STAMP

FOR SCHOOL USE ONLY:

Date	Medication/Supplies EXP DATE	Amount Rec'd (count together)	*Signature of Parent/Guardian	Signature of Receiver

Medication procedures, parent authorization, and physician's/HCP order(s) for medication(s) have been verified by the School Nurse or Principal. *If not brought in by parent, verify receipt and amount with parent by telephone. CVUSD 397ss87 REV 5-16