

# Chino Valley Unified School District

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## PARENT AND PHYSICIAN/HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION FOR ADRENAL INSUFFICIENCY AT SCHOOL AND SCHOOL ACTIVITIES

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

School Site: \_\_\_\_\_ School Fax: (909) \_\_\_\_\_ Attn: Health Office

### PARENT REQUEST/CONSENT FOR THE ADMINISTRATION OF MEDICATION FOR ADRENAL INSUFFICIENCY AT SCHOOL AND SCHOOL ACTIVITIES

I, the undersigned parent(s)/guardian(s) of the above-named student, request the specialized physical health-care service be administered to my child in accordance with state laws and regulations Ed Code 49423.5. I will: 1. Provide the necessary supplies and equipment; 2. Notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and 3. Notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization. I give consent for the credentialed school nurse to communicate with the authorized health-care provider when necessary. I understand I will be provided a copy of my child's completed Individual Health-Care Plan (IHP). 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 employees, or agents harmless from all liability, suits, or claims of whatever nature or kind that might arise out of these arrangements.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PHYSICIAN/HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION FOR ADRENAL INSUFFICIENCY AT SCHOOL AND SCHOOL ACTIVITIES

Hydrocortisone/Cortef \_\_\_\_\_ mg per tablet/capsule. \_\_\_\_\_

Fludrocortisone (0.1 mg tablet) \_\_\_\_\_ ☐ NA

NaCl \_\_\_\_\_ mEq/mL solution or \_\_\_\_\_ mg capsule \_\_\_\_\_ ☐ NA

STRESS DOSES FOR ILLNESS (ADMINISTRATION AT SCHOOL). School personnel must call parent/guardian or alternate emergency contact if any stress does is given. Stress does: Hydrocortisone/Cortef \_\_\_\_\_ mg per tablet/capsule.

If the following happens:	Then do this:
Mild to moderate illness = not eating much, headache, flu-like illness, weakness, mild head or body trauma, or temp less than or equal to 100.5F-102F	Give stress dose: _____ Call parent and Physician/HCP.
Moderate to severe illness = vomiting, diarrhea, moderate head or body trauma, or temp > 102	Give stress dose: _____ Call parent and Physician/HCP.
EMERGENCY *: vomiting more than once within 20 minutes of taking oral dose. Severe head or body trauma, profuse bleeding, seizure, fracture, lethargy, loss of consciousness, or cannot take oral stress-dose. *See CVUSD Nursing services Solu-Cortef Injection Administration Guidelines	CALL 911. Contact parent/guardian. Call Emergency contacts if parent/guardian cannot be reached. Contact Healthcare provider. EMERGENCY injectable dose (Act-o-vial)*: Solu-Cortef _____ mg/_____ mL Dose: _____ mg/_____ mL by IM injection immediately

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations. \_\_\_\_\_ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

Physician's/HCP Name (Printed) \_\_\_\_\_

Physician/HCP Signature \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Fax \_\_\_\_\_

Physician/HCP Office Stamp

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### **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

## **ADMINISTRATION OF MEDICATION AT SCHOOL DURING SCHOOL HOURS**

The following regulations and procedures will be followed when it is necessary for students to take medication at school:

1. A School Nurse, or any other school personnel, may not dispense any medication, whether prescription or over the counter, to a student without a licensed Health Care Provider order.
2. Any FDA approved prescription and over the counter medication may be administered at school when ordered by a Health Care Provider licensed by the State of California and accompanied by the appropriate written statement from the parent or guardian. A parent/guardian or designated adult must drop off medication at school.
3. Medication shall be administered by the School Nurse, trained principal, or trained designee.
4. Medications are to be supplied by the parent/guardian in the original pharmacy prescription bottle or original container labeled with the student's name, the amount of dosage (must include mgs. or number of puffs), and time of administration (include when to repeat, frequency/in how many hours needed (PRN) or daily (QD) at a specific time). List of symptoms per medication is needed.
5. Medication is to be stored in the Health Office in a locked facility or under required refrigeration. The exceptions would be upon the written request by the parent/guardian and with the approval of the student's authorized Health Care Provider, as well as approval by the School Nurse. A student with a medical condition that requires frequent treatment, monitoring, or testing may be allowed to self-administer, self-monitor, and/or self-test with the approval by the above parties. The student shall observe universal precautions in the handling of blood and other bodily fluids. Such processes shall be implemented in a manner that promotes safety and privacy. Emergency medication such as epi-pens and/or inhalers is not to be left in the lockers, purses, book bags, or other places where other students may have access to it.
6. Self-carry medication should be in the original packaging along with the Health Care Provider order and self-carry contract. All emergency medication must be kept on the student's person at all times. (Recommend that emergency supplies be kept in the Health Office)
7. At the end of the prescribed time period, or school year, parents/guardians will be notified to reclaim unused medication. Parent/guardian or designated adult must pick up medication from school. All unclaimed medication will be destroyed at the end of the student's school year.
8. Prescribed and over the counter medications which continue into a new school year require renewal by completing new parent/guardian and Health Care Provider (State of California) requests annually.
9. When students bring unauthorized medication to school, it will be retained in the office until parents/guardians have been notified about the procedure for medication at school and the requirements are fulfilled. The medication may be picked up by a designated adult or destroyed if no arrangements are made within 30 days.
10. A list of students receiving medications at school, including name of medication, time and dosage will be maintained in the office. Time given and the initials of the person administering the medication will be noted each time the medication is given. Controlled substances will need to be counted on a daily basis.
11. Each year employees designated by the principal shall receive annual competency training from the School Nurse on the administration of medication.