LOS ANGELES UNIFIED SCHOOL DISTRICT
Medical Services Division

REQUEST and PRIOR AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION TO BE TAKEN DURING OVERNIGHT FIELD TRIPS

(To be completed by a CA Licensed Health Care Provider, or a physician or surgeon from Mexico contracted with a bi-national health plan who prescribes self-administered medication in accordance with C.E.C. Section 49423.1)

Student Last Name_____, **Student First Name**_____

Student Gender_____ **Student Birthdate**____/____/____ **School**_____

IN BOX AT LEFT, PARENT/GUARDIAN SHOULD MARK **X** TO CONSENT TO SCHOOL ADMINISTRATION OF INDICATED OVER-THE-COUNTER MEDICATIONS or PRODUCTS ORDERED BY A LICENSED HEALTH CARE PROVIDER

All over the counter medications that have been prescribed by an authorized health care provider must be delivered to the school in the original container

X	Name of Over-the-Counter (OTC) Product	Provider Dosing Recommendation including time intervals, route and purpose of medication
	Acetaminophen / generic**,** Tylenol	
	Ibuprofen / generic, Advil, Motrin	
	Naproxen / generic**,** Aleve	
	Medicated skin care ointments, creams, washes aquaphor, calamine, aftersun aloe & vitamin E, neosporin, mupirocin, anti-itch diphenhydramine cream, hydrocortisone 1% steroid cream, hibiclens antibacterial wash, betadine	
	Antihistamine / generic**,** Benadryl	
	Throat Sprays, Cough Drops	
	Decongestant / generic, Dayquil	
	Allergy medication / generic, Claritin, Zyrtec, Alegra	
	Eye drops (non prescription) **/** Saline, Visine	
	Antacid / generic, Tums, Maalox, Pepto Bismol	

Licensed Health Care Provider: Print Name_____ Sign Name_____ Date _____

Print Name of Supervising Physician_____ Furnishing Number _____
For NP, PA, Midwife *For NP, PA, Midwife*

Address: Street_____ City_____ State_____ Zip _____

REQUEST FOR MEDICATIONS TO BE TAKEN DURING OVERNIGHT FIELD TRIPS – TO BE COMPLETED BY PARENT/GUARDIAN

I request that my child_____ be assisted in using the over-the-counter medication(s) and/or product(s) denoted by X while on an overnight field trip. I understand that I assume full responsibility for supplying the medication(s) or product(s) and shall deliver it, or have it delivered, to the school by a responsible adult, and agree to the District Policies and Procedures listed on the reverse side. I give my permission for the exchange of medical information regarding administration of medication at the school with the authorized healthcare provider and pharmacist.

_____ _____ ____/____/____
Printed Name of Parent/Guardian/Student over age 18 yrs **Signature of Parent/Guardian/Student over age 18 yrs** **Date**

Home Phone_____ **Work Phone**_____ **Cell Phone** _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

Printed Name of Nurse_____ **Signature**_____ **Title**_____ **Date**___/__/___

DISTRICT PROCEDURES REGARDING MEDICATION TAKEN DURING OVERNIGHT FIELD TRIPS

A. Medication Administration for Overnight Field Trips

1. The school nurse should be notified four weeks in advance of planned school-sponsored events to allow time to schedule and conduct trainings of designated school staff if medication will need to be administered.

2. Designated school staff should keep medication in a closed container on their person at all times. A copy of the Student Medication Record to document time of administration and personnel administering the medication will accompany each medication.

3. Non-prescription [over-the-counter (OTC)] medications that have been authorized by this request may be administered only if the medication is provided in the original container.

B. Administration of Non-Prescription (OTC) Medication on Overnight Field Trips

1. Before an OTC medication is administered on an overnight field trip, a designated school personnel will validate when the medication was last given to determine that the interval complies with the authorized frequency of the administration.

    a. Check Student Medication Record for time of last dose administered.

2. Before an OTC medication is administered, the designated school personnel will validate the symptoms being experienced by the student as symptoms identified on the written authorization.

3. When recording on the Student Medication Record, include the symptoms for which the OTC medication was given and the outcome after administration.

DISTRITO ESCOLAR UNIFICADO DE LOS ÁNGELES
Medical Services Division / División de Servicios Médicos

SOLICITUD Y AUTORIZACIÓN PREVIA PARA TOMAR MEDICAMENTOS DE VENTA LIBRE EN LOS PASEOS ESCOLARES CON PERNOCTA

(To be completed by a CA Licensed Health Care Provider, or a physician or surgeon from Mexico contracted with a bi-national health plan who prescribes self- administered medication in accordance with C.E.C. Section 49423.1)
(A ser completado por un profesional de la salud con licencia de CA, o un médico o cirujano de México contratado con un plan de salud binacional que recete medicamentos para el asma inhalados que porte consigo el paciente de acuerdo con el C.E.C Sección 49423.1)

Apellido del estudiante_____, **Nombre del estudiante**_____

Género del Estudiante_____ **Fecha de nacimiento del Estudiante**___/___/___ **Escuela**_____

EN EL CUADRO A LA IZQUIERDA, EL PADRE/TUTOR DEBE MARCAR **X** PARA DAR SU CONSENTIMIENTO A LA ADMINISTRACIÓN (POR PARTE DEL PERSONAL ESCOLAR) DE MEDICAMENTOS O PRODUCTOS DE VENTA LIBRE QUE INDIQUE UN PROFESIONAL DE ATENCIÓN MÉDICA CON LICENCIA

Todos los medicamentos de venta libre que han sido recetados por un profesional de atención médica autorizado deberán ser entregados a la escuela en el recipiente original

X	Name of Over-the-Counter (OTC) Product	Provider Dosing Recommendation including time intervals, route and purpose of medication
	Acetaminophen / generic**,** Tylenol	
	Ibuprofen / generic, Advil, Motrin	
	Naproxen / generic**,** Aleve	
	Medicated skin care ointments, creams, washes aquaphor, calamine, aftersun aloe & vitamin E, neosporin, mupirocin, anti-itch diphenhydramine cream, hydrocortisone 1% steroid cream, hibiclens antibacterial wash, betadine	
	Antihistamine / generic**,** Benadryl	
	Throat Sprays, Cough Drops	
	Decongestant / generic, Dayquil	
	Allergy medication / generic, Claritin, Zyrtec, Alegra	
	Eye drops (non prescription) **/** Saline, Visine	
	Antacid / generic, Tums, Maalox, Pepto Bismol	

Licensed Health Care Provider: Print Name_____ Sign Name_____ Date _____

Print Name of Supervising Physician_____ Furnishing Number _____
For NP, PA, Midwife *For NP, PA, Midwife*

Address: Street_____ City_____ State_____ Zip _____

SOLICITUD DE MEDICAMENTOS QUE SE TOMARÁN DURANTE PASEOS ESCOLARES CON PERNOCTA – A SER COMPLETADO POR EL PADRE/TUTOR

Solicito asistencia para mi estudiante con el uso de los medicamentos de venta libre y/o productos indicados con una X durante un paseo escolar con pernocta. Entiendo que asumo la responsabilidad total del suministro de medicamentos o productos y de que se entreguen en la escuela por mi parte o la de un adulto responsable; asimismo, estoy de acuerdo con las Políticas y Procedimientos del Distrito enumerados al reverso. Autorizo el intercambio de información médica sobre la administración de medicamentos en la escuela con el médico y el farmacéutico autorizado.

Nombre impreso del padre/tutor/estudiante mayor de 18 años **Firma del padre/tutor/estudiante mayor de 18 años** ____/____/____ **Fecha**

Teléfono del hogar_____ **Teléfono del trabajo** _____ **Celular**_____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

Printed Name of Nurse_____ **Signature**_____ **Title**_____ **Date**____/___/___

PROCEDIMIENTOS DISTRITALES SOBRE MEDICAMENTOS QUE SE TOMEN DURANTE PASEOS ESCOLARES CON PERNOCTA

A. Administración de medicamentos para paseos escolares con pernocta

1. El personal escolar de enfermería deberá ser notificado con cuatro semanas de anticipación sobre los eventos patrocinados que planee la escuela, con el fin de tener tiempo para programar y llevar a cabo la capacitación para el personal escolar designado en caso de que sea necesario administrar medicamentos.

2. El personal escolar designado debe mantener los medicamentos en un recipiente cerrado y tenerlo consigo en todo momento. Cada medicamento irá acompañado de una copia del Registro de Medicamentos del Estudiante para documentar la hora de administración y el personal que administre el medicamento.

3. Los medicamentos que no requieren receta (es decir, de venta libre al público, u OTC por sus siglas), que hayan sido autorizados mediante la presente solicitud, se podrán administrar únicamente si se proporcionan en su envase original.

B. Administración de medicamentos sin receta (OTC) en paseos escolares con pernocta

1. Antes de que se administre un medicamento de venta libre en un paseo escolar con pernocta, un miembro designado del personal escolar verificará la última vez que se haya administrado el medicamento para determinar que el intervalo cumpla con la frecuencia de administración autorizada.

    a. Revisar el registro de medicamentos estudiantiles para verificar la hora de la última dosis administrada.

2. Antes de administrar un medicamento de venta libre, el personal escolar designado confirmará los síntomas que tenga el estudiante como síntomas identificados en la autorización escrita.

3. Al documentar en el Registro de Medicamentos Estudiantiles, incluir los síntomas para los cuales se administró el medicamento de venta libre y el resultado después de la administración.