LOS ANGELES UNIFIED SCHOOL DISTRICT
Policy bulletin

LOS ANGELES UNIFIED SCHOOL DISTRICT

Medical Services Division

REQUEST FOR SELF-CARRY OF EMERGENCY MEDICATION DURING SCHOOL HOURS

Student's Last Name _____ First Name _____ Gender _____ Birth date _____ School _____

Name of Medication _____ Start Date _____

Dosage Prescribed _____ Time/Frequency _____ Route _____
(Mouth, Ear, Eye, Etc.)

How long is medication to be taken: ☐ 1 year ☐ short-term _____
Date medication to be discontinued or # of days to be given

Purpose of medication or diagnosis _____ ICD Code _____

LICENSED HEALTH CARE PROVIDER (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-carried, inhaled asthma medication in accordance with C.E.C. Section 49423.1)

This student's medical condition requires immediate use of _____(medication) and the student's wellbeing is in jeopardy unless the medication is carried on the student's 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 carrying this medication. Medication is to be used by the student as indicated above and will be administered by trained voluntary school personnel.

Please check where applicable:

☐ The medication may have adverse side effects (explain): _____

☐ Special Instructions and/or comments: _____

The student for whom this medication is prescribed is under my care.

Print name of licensed health care provider _____ Signature _____ Date _____

_____ ( ) _____
Address City State Zip Code Telephone

_____ _____
Print name of Supervising Physician (if N.P., Midwife or P.A.) Furnishing Number (if N.P. or Midwife)

PARENT/GUARDIAN

I request that my child, _____, be allowed to self-carry and be assisted by trained voluntary school personnel in administering the prescribed medication at school. I assume full responsibility for supplying all medication and agree to the District 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-carrying this medication. I hereby expressly waive and release the Los Angeles Unified School District from any and all rights or claims of any nature whatsoever I may have against the Los Angeles Unified School District, the Board of Education of the Los Angeles Unified School District, and its members, volunteers and employees, arising out of, in connection with, or resulting from the above request.

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

_____ _____ _____
Print name of parent or guardian Signature Date

( ) _____ ( ) _____ ( ) _____
Telephone Work telephone Cellular telephone

SCHOOL PERSONNEL

I have received the request of the parent/guardian and orders of the above licensed health care provider and believe that the above student is physically, mentally, and behaviorally capable of self-carrying this medication at school.

_____ _____ _____
Signature of School Principal Signature Date

DISTRICT PROCEDURES REGARDING SELF-CARRY OF EMERGENCY MEDICATION DURING SCHOOL HOURS

1. Prescription medications must be clearly labeled by a U.S. dispensing pharmacy and contain the following information: (consistent with prescription of authorized licensed health care provider)

    - Student's full name
    - Physician's name
    - Dosage, schedule, and route.
    - How long does medication is to be taken? 1 year or short-term (date medication is to be discontinued or number of days medication is to be administered.)

2. Non-prescription (over the counter) medications that have been authorized by this request, must be in the original container.

3. Requests for Self-Carry of Medication during School Hours must be renewed annually.

4. Parent/Guardian will notify the school nurse or site administrator and provide a new Request for Self-Carry of Medication During School Hours when there is a change in the student's medication, health status or authorized health care provider.

5. Injectable medications, which are to be given on an emergency basis require special arrangements and training of school staff by the credentialed school nurse.

6. A copy of this authorization should be carried with the medication

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Name of Student / Nombre del estudiante	Birth date /Fecha de nacimiento	School / Escuela

STUDENT CONTRACT FOR SELF-CARRY OF EMERGENCY MEDICATION DURING SCHOOL HOURS

I am requesting to carry my medication at school, and I agree to do the following:

- I will tell the school nurse or_____(trained voluntary school personnel) if there are any problems with my medication, supplies or equipment.

I understand that any misbehavior with my medication, such as sharing medications with other students or not safely handling equipment, will mean the school administrator or school nurse can take away my self-carry privilege.

ACUERDO ESTUDIANTIL PARA PORTAR MEDICAMENTOS DE EMERGENCIA DURANTE EL HORARIO ESCOLAR

Solicito autorización para llevar mi medicamento a la escuela, y acepto lo siguiente:

- Le notificaré al enfermero escolar o_____ (personal escolar capacitado de manera voluntaria) en caso de surgir algún problema con el medicamento, suministros, o equipo.

Comprendo que cualquier clase de conducta indebida con los medicamentos, como compartirlos con otros estudiantes o usar de manera inapropiada los suministros, dará como resultado que el administrador o enfermero escolar me retiren el privilegio de portar medicamentos.

Signature of Student / *Firma del estudiante*	Date / *Fecha*
Signature of School Nurse/ *Firma del enfermero escolar*	Date / *Fecha*