

**OAKDALE JOINT UNIFIED SCHOOL DISTRICT
OFFICE OF HEALTH SERVICES**



Oakdale High School
739 West "G" Street
848-7193 Fax: 848-5841

Oakdale Jr. High School
400 Maag Avenue
847-2294 Fax: 847-8521

Cloverland Elementary
201 Johnson Avenue
847-4276 Fax: 847-9059

Magnolia Elementary
739 Magnolia Avenue
847-5056 Fax: 848-0815

Fair Oaks Elementary
151 North Lee Avenue
847-0391 Fax: 847-9067

Sierra View Elementary
1323 East J Street
848-4200 Fax: 848-4203

District Office 168 South 3rd Avenue (209) 848-4884 Fax: (209) 847-0155

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL
(Only for auto-injectable epinephrine or inhaled medication)

Student: _____ Birth Date: _____

School: _____ Teacher/Grade: _____

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER	
<u>MEDICATION</u>	
Medication name: _____	
Reason for Medication: _____	
Dose: _____	
Method of Administration: _____	
Time of Administration: _____	
Start: <input type="checkbox"/> Immediate <input type="checkbox"/> Other date: _____	
End: <input type="checkbox"/> End of Year <input type="checkbox"/> Other date/duration: _____	
<input type="checkbox"/> For episodic/emergency events only	
Restrictions and/or important side effects	
<input type="checkbox"/> None anticipated	
<input type="checkbox"/> Yes, please describe: _____	
Special Storage Requirements:	
<input type="checkbox"/> Refrigerate <input type="checkbox"/> None	
This student is both capable and responsible for self administering auto-inject able epinephrine or inhaled asthma medication.	
<input type="checkbox"/> Yes – Supervised <input type="checkbox"/> Yes- Unsupervised <input type="checkbox"/> No	
This student may carry medication: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please indicated any additional comments: _____	

SCHOOL INHALER PROCEDURES

Medication must be dispensed per procedures described by Health Care Provider Authorization.

Responsibilities for carrying respiratory inhalers:

OBSERVED

- | | | |
|-----|-----|---|
| YES | NO | |
| ___ | ___ | "Request for Administration of Medication" form has been completed. |
| ___ | ___ | Student demonstrated correct use of inhaler. |
| ___ | ___ | Student agrees not to share inhaler with other students |
| ___ | ___ | Student agrees to carry inhaler with him/her at all times |
| ___ | ___ | Parent has provided a second inhaler to be kept in the Health Office. If a second inhaler is not provided and student need medication, the district will contact Emergency Services (911) |
| ___ | ___ | Student agrees to come to the Nurse/School office if he/she continues to have difficulty breathing, wheezing, or experiencing chest tightness after using their inhaler. |

Student Signature Date

School Nurse Signature Date

Comments:
MY CHILD WILL BE RESPONSIBLE FOR CARRYING THIS RESPIRATORY INHALER DURING SCHOOL HOURS AND WILL SELF ADMINISTER HIS/HER MEDICATION AS NEEDED. MY CHILD AGREES TO FOLLOW THIS DISTRICT'S PROCEDURES REGARDING THE ADMINISTRATION OF HIS/HER MEDICATION.

Parent/ Guardian Signature Date

Please complete side two (over)

Health Care Provider/Physician Signature: _____ **Date** _____

Physician Name: _____
Phone # _____ (or)
Address: _____

Physician's Office Stamp: _____

**CONSENT FOR SELF-ADMINISTRATION OF MEDICATION
RELEASE OF MEDICAL INFORMATION AND
RELEASE OF LIABILITY**

I hereby consent for my child, _____ to self-administer the following medication during the regular school day or when attending school related activities.

- Auto-Injectible Epinephrine Inhaled asthma medication

I also consent to disclose identifiable health information by the health care provider to the school nurse or other personnel designated by: _____.

I acknowledge that I have an obligation to notify the school if my child's medication, dosage, frequency, of administration or reason for administration changes during the school year.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to indemnify and hold harmless, release and covenant not to sue the District, its officers, employees, and agents, for any and all liability, claim or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self-administration of medication.

Date

Signature of Parent/Guardian

Printed Name of Parent/Guardian

Date _____ Reviewed by School Nurse

Signature of School Nurse

Date _____ Reviewed by Principal

Signature of Principal

This request **MUST** be updated annually and medication claimed within one week beyond the end of the school year.
Unclaimed medication will be discarded.