

REQUEST FOR MEDICATION TO BE SELF CARRIED SOUTH CAMPUS ONLY

TO BE COMPLETED BY A LICENSED PHYSICIAN AND PARENT/GUARDIAN.

California Education Code Section, 49423 allows the School board of Hillcrest Christian School dba Heritage Christian School to provide that the principal or his/her designee may assist in carrying out a physician's recommendations with respect to any pupil who is required to take medication during the regular school day. The staff recognizes the desirability of following a physician's recommendations as nearly as possible at school or school sponsored overnight trips. The fact that this is a service or accommodation that the school is not legally required to perform is recognized by all parties signing this form, and in so signing they agree to hold the school or its personnel free from any or all claims, demands, or suits which might arise out of these arrangements.

Student's Name _____ Birthdate _____ Gender M F

LICENSED HEALTH CARE PROVIDER

The below section should be filled out by a health care professional ONLY.

Name of Medication _____ Start Date _____

Dosage Prescribed _____ Time/Frequency _____ Route _____

How long is it to be taken? _____ Purpose of medication? _____

Precautions, Special Instructions, Possible Adverse Effects, Comments:

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Signature _____ Date _____

Approval for Self-Administration of Rescue Medications (including by not limited to inhaler and epinephrine auto-injector)

This student's medical condition requires immediate use of the above non-controlled, prescribed medication. The student's well being is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student is under my care and has been instructed how to use this medication safely and has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication accurately and independently.

Please initial IF you approve of this student to self-carry _____



PLEASE CONTINUE FORM ON THE BACK

PARENT

The below section should be filled out by the parent ONLY.

I request that my student be assisted in taking the above prescribed or over the counter medication during school hours or on school sponsored travel by an authorized staff member, and will comply with the school’s policies and procedures. This is to certify that I have read the physician’s recommendations and approve the medicine and medication as set forth herein and request that school personnel assist my child in matters detailed herein. Further, I hereby agree to hold harmless and indemnify the school board, trustees and employees from all claims, damages, or expenses arising out of any injury or death of any person, or damage to property which may result from administering said medication or from any harmful effects of same.

Parent’s Name _____ Phone _____

Signature _____ Date _____

Approval for Self-Administration of Rescue Medications (including by not limited to inhaler and epinephrine auto-injector)

In addition to the physicians recommendation that the above named student be able to self-carry this non-controlled medication, I, the below named parent/guardian, give him/her my permission to carry it at school and self-administer the above named medication. All controlled medication as defined by this U.S. Department of Justice Drug Enforcement Administration must be held and administered in the Health Office.

Please initial IF you approve of your student to self-carry _____

Please note: All prescription medication must be in the original container with the printed directions on the label. Nonprescription medications will not be given at any time without the above written authorization and instruction from the child’s physician.

STUDENT

The below section should be filled out by the student ONLY, AND IF the student is asking to self-carry the above named medication.

By signing below I understand and agree that:

- The above named medication is strictly for my own use and will not be shared with or provided to any other student.
- This is a revocable privilege.
- I must check-in with the Health Office or coach as soon as I self-administer the above named medication.

Student’s Name _____

Signature _____ Date _____

OFFICE USE ONLY

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.

Principal Signature _____ Date _____

Health Office Signature _____ Date _____

QR Code ID Number _____

PROCEDURES REGARDING REQUEST FOR ANY MEDICATION TO BE DISPENSED BY SCHOOL PERSONNEL

Heritage Christian School is committed to the safety and well being of all our students. Our policies have been adapted from recommendations from the California Department of Education's Program Advisory on Medication Administration. Here are some highlighted policies:

1. ALL medications prescribed or Over the Counter (including pepto bismol, tylenol, vitamins, etc) must have a physician's written order as well as parent's written permission which is documented on our HCS form titled "A Request for Medication to be Dispensed by School Personnel" found on the HCS website.
2. In order for a staff member to administer medications to your child during the school hours, the above mentioned form must be completed and on file for your child in our Health Office.
3. All medication brought to school must be in the original box or container. Prescriptions must be pharmacy labeled. The following information must be on the medication container: Student's full name, physician's name and phone number, name of medication, dosage, schedule, dose form, and date of expiration of the prescription.
4. A parent/guardian must personally deliver any medication to be given at school, as a verification signature is required upon delivery of the medication. All medication must not expire before the end of the school year.
5. If it is not possible for an adult to deliver the medication, please contact the school office to discuss delivery of the medication
6. Medications will be disposed of after 30 days of the email notification from the Health Office, asking that the medication needs to be picked up for any reason (expired, missing information, not properly logged in, etc.)

Please contact your student(s)' campus during Health Office hours to make arrangements to drop off all medications and authorization forms. Should a student need access to their rescue medications (such as EpiPens, insulin, or inhalers) after normal school hours, after-school care supervision is prepared to access their medications. Please refer to the Parent Student Handbooks at your student(s)' campus for additional details, or call the office.