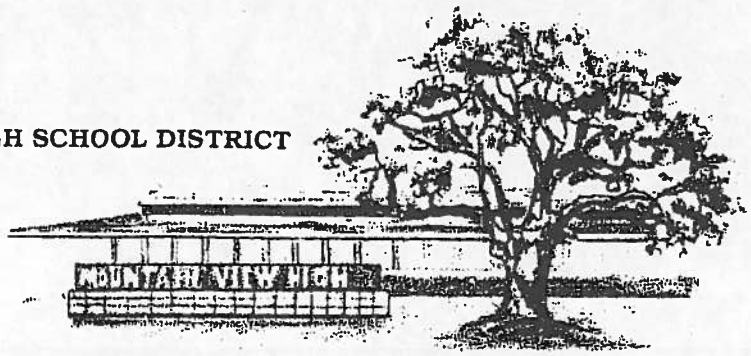
MOUNTAIN VIEW-LOS ALTOS UNION HIGH SCHOOL DISTRICT

Mountain View High School
3535 Truman Avenue
Mountain View, CA 94040-4598
(650) 940-4600



INFORMATION FOR PARENTS REQUESTING SCHOOL PERSONNEL TO ADMINISTER MEDICATION DURING SCHOOL HOURS

Dear Parent(s)/Guardian(s):

Medical treatment is the responsibility of the parent and the family physician; medications are rarely given in school. The only exceptions to this general rule involve special or serious problems. The school district will consider assisting in administering medication only when it is deemed absolutely necessary to give the medication during school time and only when the school has received appropriate statements from both the parent and attending physician regarding the administration of that medication.

Parents are advised that a school nurse serves more than one school and is not available to administer medications. The principal, secretary, or other designated employee, therefore, will likely be the person administering the medication. Because it is not deemed the responsibility of schools or school personnel to administer medications, **parents are urged**, with the help of the family physician, to work out a schedule of giving medication outside school hours.

Parents must provide the school with a written statement (Physician's Authorization for the Administration of Medicine by School Personnel; HHS: 6/97) from the attending physician which gives specific directions for the administration of the medication to be given at school. California law requires that the physician's statement detail "the method, amount, and time schedules by which medication is to be taken." (CEC 49423)

California law also requires that before any medication can be administered, the District must receive a signed release from the parents/guardians (Parent/Guardian Statement; HHS: 6/97), indicating their desire that the school district assist the pupil in the manner set forth in the physician's statement. (CEC 49423)

Finally, the attending physicians must renew medication for non-episodic orders in a release signed by the parents/guardians at the beginning of each school year or upon entrance to school.

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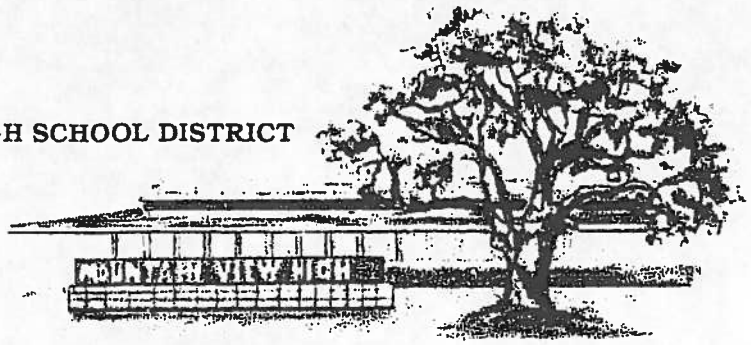

PHYSICIAN'S AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

California Education Code Section 49423 provides that the school nurse, or any other designated school personnel, may assist pupils who are required to take medications during regular school days only when such medications are prescribed by a physician and only if the school district receives specified written statements from the physician as well as the parents or guardians of the pupil.

The following form must be completed in its entirety by the attending physician. For non-episodic conditions this form must be re-submitted on an annual basis.

AUTHORIZATION TO ASSIST IN ADMINISTRATION OF MEDICATION

1. Name of Pupil:_____
2. Birthdate:_____ School:_____
3. Address:_____
4. Physical condition for which medication is to be given:_____
   _____
   _____
5. Name of Medication:_____
6. Method of Administration:
   ☐ Tablets ☐ Liquid ☐ Inhaler
7. Dose:_____ Schedule of Doses:_____
8. This medication is to be continued as above until:_____
9. Precautions, possible reactions, and interventions:_____
   _____
   _____

Physician's Signature:_____ Date:_____

Address:_____ Phone:_____

_____

(HHS 8/99)

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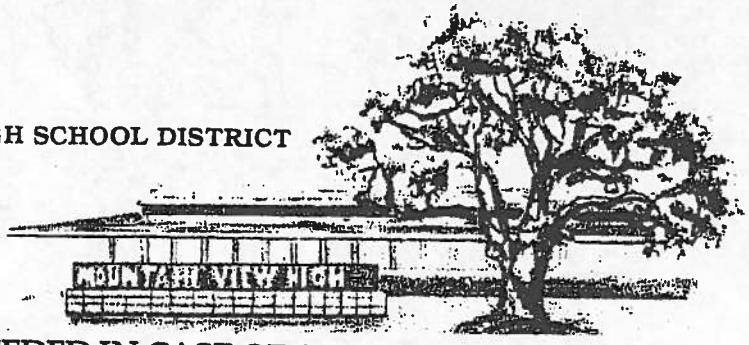

MEDICATION(S) NEEDED IN CASE OF A DISASTER

Student:_____ Date:_____ Phone:_____

Address:_____ City:_____ Zip:_____

Dear Parent/Guardian:

As part of our Disaster Preparedness Plan, we are trying to provide for all aspects of your child's care, including the administration of medication(s). In anticipation that you may be separated from your child for possibly 72 hours, we must have on file a doctor's prescription for life-sustaining medication(s). Please take this letter to your physician who will list all the medications that must be administered to your child in order to maintain therapeutic levels. **Please return this completed form to your school site. Remember to promptly notify the school of any changes.**

Although we will try our best to provide your child with these medications, we cannot guarantee that circumstances will allow us to do so in the event of a major disaster.

To the Physician:

This will serve as a prescription for the individual named above. Both the parent and I recognize that circumstances beyond anyone's control may prevent the dispensing of these medications.

Indicate medications that **must** be given over a 24-hour period. Note dose and time and route of administration. **Write clearly.**

Drug	Dose	Route	Time

_____ _____ _____
(Physician's Signature) (License #) (Date)

_____ _____ _____ _____
(Address) (City) (Zip) (Phone)

_____ _____
(Parent/Guardian) (Date)

(HHS 8/99)

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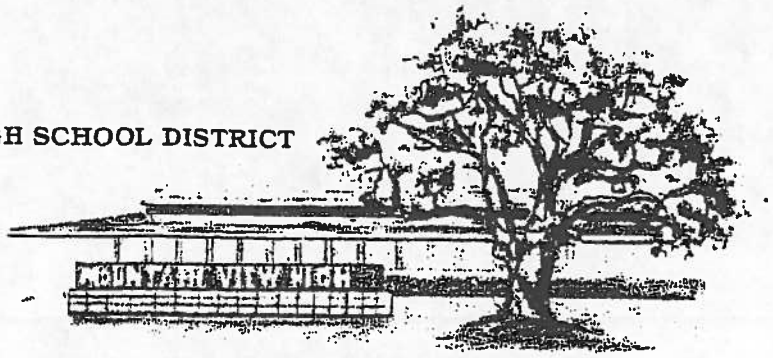

PARENT/GUARDIAN STATEMENT

I have read page one of this form and understand that by signing this document, I am releasing the Mountain View – Los Altos Union High School District, along with its employees and agents, from any and all liability for personal injury, including physical, emotional, pain and suffering injuries and/or property loss and damage which _____ incurs as a
(Student's Name)
result of school personnel administering prescribed medication. I further agree to indemnify the MVLA Union High School District, its employees and agents against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

We are the parents and/or guardians of _____ and hereby
(Student's Name)
request that a member of the school staff administer medication to our child in accordance with the physician's _____ instructions. I will notify the school
(Physician's Name)
immediately if we change physicians or if the medication is changed. I understand that this authorization must be renewed for non-episodic medication at the beginning of each school year or upon entrance to a new school.

_____ _____

Parent's/Guardian's Signature Parent's/Guardian's Signature

_____ _____

Home Phone Business Phone

_____ _____

Address Date

PLEASE SEND A CURRENT PHOTO OF THE STUDENT

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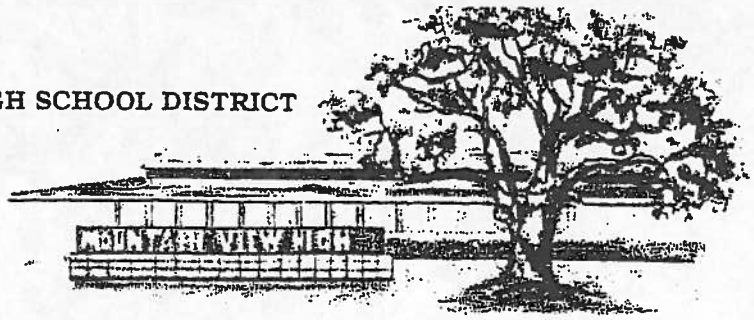

REQUEST FOR STUDENT TO CARRY MEDICATION IN SCHOOL

Administrative Statement:

It is the policy of the MVLA Union High School District to prohibit students carrying medications while at school or to and from school. Exceptions will be made when the **physician believes that a life-threatening situation could result if the student does not have immediate access to the medication.**

Written Statement from Physician:

Student's Name: _____ Date of Birth: _____

Address: _____

I certify that _____ **must** carry _____
(Student Name) (Medication Name)

with her/him at all times at school due to _____

_____
(Medical Condition)

This condition is such that there is inadequate time for the student to go to the office to obtain the medicine. I have instructed the student in the proper administration of this medication and have certified that he/she needs no adult supervision. I have further instructed the student in the dangers of giving the medication to anyone other than herself/himself. I have discussed the above-stated risks and liabilities with the parent.

Physician's Signature: _____

Address: _____

Phone: _____ Date of Request: _____

Parent Signature: _____ Date: _____

This form must be completed in addition to the *Physician Authorization for the Administration of Medicine by School Personnel.*

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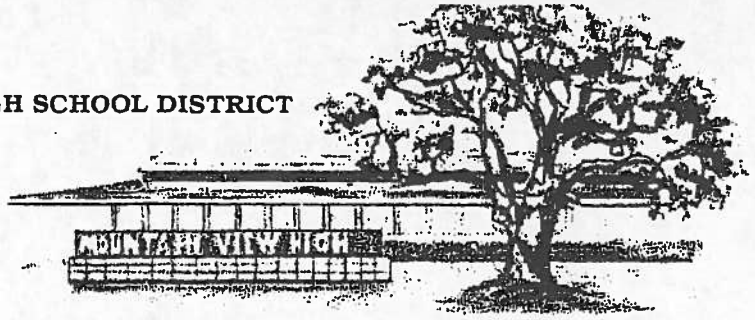

Medication Administration Procedure for School Personnel

The following guidelines for the administration of medication are to be followed for **any medication, whether prescription or non-prescription.** This applies for Tylenol, cold medicines, etc.

CHECK-IN

1. Check medication release form against medication container. They must match. (Name of child, medication, dosage, frequency, and route.)
2. Parent and Physician Authorization forms must be completed for episodic and non-episodic medication; non-episodic medication orders must be renewed by the attending physician and a release form signed by the parent at the beginning of each school year.
3. **Medication must be in its original container. Medication not in its original container may never be given. Check expiration date** on medication bottle; if expired, do not give, and contact parent.

****** The above three conditions must have been met before you can give the medication.***

4. Place medication authorization forms and medication bottle in plastic bag; label bag with child's first and last name and picture whenever possible.
5. Medications are to be kept in a locked cabinet and/or out of reach of any children. Children are never allowed to get their own medication.
6. Fill out medication log sheet.
7. Double-check. You may want to do this with the other secretary/clerk since you'll probably both be giving the medication. Only staff who have been trained in the medication procedure may administer it.

ADMINISTRATION

1. Before giving the medication, check with student, other secretary and against medication record that dosage for that time/day has not already been given.
2. **Every time you give the medication, make sure you have checked "The Five Rights" comparing the medication bottle and the medication release form.**

    (1) The right student
    (2) The right medication
    (3) The right dosage
    (4) The right time
    (5) The right route

DOCUMENTATION

1. All medication given must be documented; document immediately after giving the medication. Purpose: Shows you gave it as ordered and followed the physician's directions correctly. Also prevents others from double-dosing the students.

ALERT!

Because of the increased incidence of Reye's Syndrome in children who have been given aspirin, <u>aspirin should not be given to children under the age of 18</u>. If a student should bring aspirin to school, call the school nurse who can then contact the physician and parent. (There are isolated instances when due to the child's diagnosis, aspirin can be used, but the school nurse needs to verify it with the doctor. Be aware of products that contain aspirin (salicylic acid) such as Pepto Bismol.

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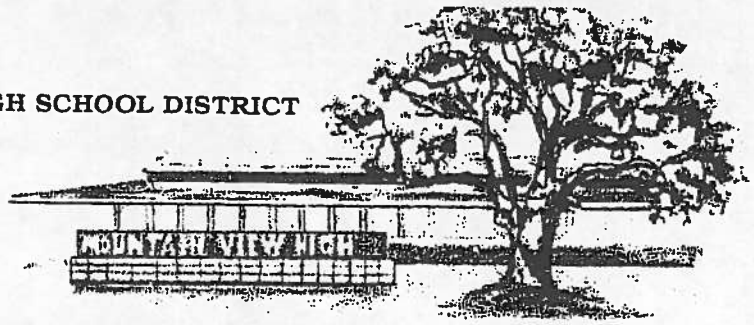

ANAPHYLACTIC REACTION EMERGENCY PROCEDURE
SPECIALIZED PHYSICAL HEALTH CARE SERVICES PROCEDURE

Student's Name:_____ Birthdate:_____

Specific Allergy:_____

Physician's Office Phone:_____ Hospital of Choice:_____

Parent/Guardian Name:_____

EMERGENCY NUMBERS

Home:_____

Mother's Work:_____

Father's Work:_____

Other:_____

Possible Symptoms of Anaphylactic Reaction

Hives	*Dizziness*	*Abdominal Cramps*	*Loss of Consciousness*
Nausea	*Fast Pulse*	*Cold Clammy Skin*	*Puffy swelling of lips and eyes*
Wheezing	*Apprehension*	*Difficulty Breathing*	*Swelling of the Throat (Laryngeal Edema)*

PROCEDURE TO FOLLOW: DO NOT WAIT FOR SYMPTOMS TO APPEAR!!

1. If a child has been stung or has a severe allergic reaction, designated personnel will immediately administer EPIPEN Jr. Auto-Injector (0.3 mg. of Epinephrine) intramuscularly.
   - Wipe area on thigh with alcohol (if available). Pull off gray safety cap on EPIPEN.
   - Place black tip on thigh, at right angle to leg. (Always apply to thigh.)
   - Press hard into thigh until Auto-Injector mechanism functions, and hold in place for 10 seconds. The EPIPEN unit should then be removed from thigh and discarded into needle container. Massage the injected area for 10 seconds.
   - In addition, if child is able to swallow, give _____ mg. of **Benadryl** by mouth.
     _____ Time before administering EPIPEN.
     _____ Time after administering EPIPEN.
2. In the meantime, the secretary will immediately:
   - **Call 911.** Notify them that child has been given epinephrine for a possible anaphylactic reaction to _____.
   - Call parents. Notify the physician at the emergency room that 911 has been called for transportation to the hospital.
   - Copy Emergency Card.
3. Keep child lying down with feet elevated. Keep warm. Ensure adequate airway.
4. IF BREATHING STOPS AT ANY TIME DURING PROCEDURE, INITIATE RESCUE BREATHING IMMEDIATELY. IF BREATHING AND PULSE STOP, INITIATE CPR IMMEDIATELY.
5. Stay with student until paramedics arrive. If parents are unavailable, a staff member will accompany student to hospital with copy of the Emergency Card. Remain with student until parents arrive.

_____ _____
(Physician's Signature) (Date) (District Nurse's Signature) (Date)

_____ _____
(Parent/Guardian Signature) (Date) (Principal Signature) (Date)

Persons trained to administer EPIPEN: _____ _____

_____ _____

(HHS 8/99)