COVINA-VALLEY UNIFIED SCHOOL DISTRICT STUDENT SERVICES

Consent to Self-Administer Medication During School Hours

Last Name	**First Name**	**Gender**	**Birth Date**	**School**

LICENSED HEALTH CARE PROVIDER (To be completed by a Licensed Health Care Provider)

Purpose of medication or diagnosis _____ ICD-10 Code _____

Name of Medication _____ Start Date _____

Dosage Prescribed _____ Time/Frequency _____ Route _____

How long medication is to be taken? ☐1 year ☐short term _____

Date medication to be discontinued or # of days to be given

TO BE COMPLETED BY A LICENSED PHYSICIAN

This student's medical condition requires immediate use of _____ (medication) and 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 has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

Please check where applicable:

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

☐ Special instructions and/or comments: _____

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

Print name of licensed healthcare provider	Signature	Date

Address	City	State	Zip Code	Telephone

PARENT/GUARDIAN

I request that my child, _____, be allowed to self-administer the 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 student is physically, mentally, and behaviorally capable of self-administering this medication. I hereby expressly waive and release the Covina-Valley Unified School District from any and all rights or claims of any nature whatsoever I may have against the Covina-Valley Unified School District, the Board of Education of the Covina-Valley 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-administration of medication at school with the authorized health care provider and pharmacist.

Print name of parent/guardian	Signature	Date

Telephone	Work Telephone

COVINA-VALLEY UNIFIED SCHOOL DISTRICT STUDENT SERVICES

Consent to Self-Administer Medication During School Hours

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-administering this medication at school.

_____	_____	_____
Print name of school nurse	Signature of school nurse	Date

DISTRICT PROCEDURES REGARDING SELF-ADMINISTRATION OF 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)

    a. Student's full name
    b. Physician's name
    c. Dosage, schedule, and route.
    d. How long 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-Administration 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-Administration 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.

Thank you, ***Covina-Valley Health Services***

Office: 626-974-6435 ; **Fax**: 626-974-6436

COVINA-VALLEY UNIFIED SCHOOL DISTRICT STUDENT SERVICES

Consentimiento de Auto Administrar Medicamento Durante Horas Escolares

_____

Apellido **Nombre** **Género** **Fecha de Nacimiento** **Escuela**

LICENSED HEALTH CARE PROVIDER (To be completed by a Licensed Health Care Provider)

Purpose of medication or diagnosis _____ ICD-10 Code _____

Name of Medication _____ Start Date _____

Dosage Prescribed _____ Time/Frequency _____ Route _____

How long medication is to be taken? ☐1 year ☐short term _____

Date medication to be discontinued or # of days to be given

TO BE COMPLETED BY A LICENSED PHYSICIAN
(SER COMPLETADO POR UN MÉDICO CON LICENCIA)

This student's medical condition requires immediate use of _____ (medication) and 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 has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

Please check where applicable:

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

☐ Special instructions and/or comments: _____

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

_____ _____ _____

Print name of licensed healthcare provider Signature Date

_____

Address City State Zip Code Telephone

PADRE/TUTOR

Solicito que mi hijo, _____, se le permita auto-administrarse el medicamento en la escuela. Asumo total responsabilidad de proveer todo el medicamento y acepto las pólizas y procedimientos del Distrito anotadas al reverso. Solicito que la escuela cumpla con las órdenes del médico licenciado mencionado arriba.

Creo que mi estudiante tiene la capacidad física, mental, y conducta para auto-administrar este medicamento. Por lo presente expresamente renuncio y liberó al Distrito Escolar Unificado de Covina-Valley de cualquier y todos los derechos o reclamos de cualquier naturaleza que pueda tener contra el Distrito Escolar Unificado de Covina-Valley, el Consejo de Educación del Distrito Escolar Unificado de Covina-Valley, y sus miembros, voluntarios y empleados, que surjan de, en conexión con, o como resultado de la solicitud arriba.

Doy mi permiso para el intercambio de información médica tocante la administración del medicamento en la escuela con el médico licenciado y el farmacéutico.

_____ _____ _____

Nombre escrito de los padres/tutor Firma Fecha

_____ _____

Teléfono Teléfono del trabajo

Rev. 4/08; 7/17; 12/22; 02/23

Consentimiento de Auto Administrar Medicamento Durante Horas Escolares

---

PERSONAL ESCOLAR

He recibido la solicitud de los padres/tutores y las órdenes del médico licenciado mencionado y creo que el estudiante mencionado tiene la capacidad física, mental y de conducta para auto administrarse este medicamento en la escuela.

_____	_____	_____
Nombre escrito de la enfermera escolar	Firma de la enfermera escolar	Fecha

DISTRICT PROCEDURES REGARDING SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

1. Los medicamentos recetados deben estar claramente etiquetados por una farmacia dispensadora de EE. UU. y contener la siguiente información: (consistente la receta de un médico autorizado y licenciado)
    a. Nombre completo del estudiante
    b. Nombre del médico
    c. Dosis, horario y ruta de administración
    d. ¿Cuánto tiempo debe tomar el medicamento? 1 año o corto plazo: (Fecha que debe descontinuar el medicamento o número de días que se administra el medicamento.)
2. Los medicamentos sin receta (de venta libre) que hayan sido autorizados por esta solicitud, podrán administrarse en la escuela solo si el medicamento es proveído en el frasco original.
3. La Solicitud para Auto-Administrar el Medicamento Durante las Horas Escolares se debe renovar cada año.
4. Los padres/tutores notificarán a la enfermera escolar o al administrador del sitio y proveer una nueva Solicitud para Auto-Administrar el Medicamento Durante las Horas Escolares cuando haya un cambio en el medicamento, estado de salud o médico autorizado del estudiante.
5. Los medicamentos inyectables, que deben administrarse en caso de emergencia, requieren arreglos especiales y entrenamiento del personal escolar por parte de la enfermera escolar licenciada.
6. Una copia de esta autorización se debe cargar con el medicamento.

Gracias, ***Servicios de Salud de Covina-Valley***

Oficina: 626-974-6435 ; **Fax**: 626-974-6436

Rev. 4/08; 7/17; 12/22; 02/23