Orange County Department of Education
Instructional Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: _____ Birthdate: _____
School/District: _____ Teachers Name: _____ Grade/Track: _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: _____ Date: _____

Telephone: (Work) _____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication: _____ Dose: _____ Route: _____ Time: _____

If PRN: Amount of time between doses _____ Maximum number of doses _____ per day.

Possible medication reactions: _____

Instructions for emergency care _____

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (print clearly): _____

Telephone _____

Date of Request: _____

Date to Discontinue Medication: _____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:

Reviewed by: _____ Date: _____

This request is valid for a maximum of one year.

School Participation Following Injury

부상에 따른 학교 활동 참여

Student Name _____ **Date of Birth** _____
학생이름 생년월일

School _____ **Grade** _____ **Teacher** _____
학교 학년 교사

Diagnosis _____ **Date of Injury** _____
진단 부상 날짜

The above-named student may return to school on _____
위의 학생이 학교에 다시 출석할 수 있는 날짜

Student will return to school with: ○ No Assistive Device 보조기구 없이
학생이 학교에 재 출석할 때 함께 사용하게 될 기구들:

○ Wheelchair 휠체어 ○ Cast 캐스트/기부스 ○ Crutches 목발 ○ Walking Boot 보행신발 ○ Brace 금속보호대

○ Sutures 봉합 ○ Walker 보행기 ○ Sling 매는 장치 ○ Elastic Bandage 탄력붕대 ○ Splint 부목

○ Other Device 기타 보조기구 _____

I have examined the above named student and consider him/her able to participate in regular school activities with the folllowing recommendations: 위의 언급된 학생을 검사하였고 다음 권고 사항들과 함께 정규 학교 활동에 참여할 수 있을 것으로 고려됩니다.

Recommendations for Recess 쉬는시간: ☐ *May participate 참여할 수 있음* ☐ *May not participate 참여하지 못함*
☐ *May not participate, but may circulate with peers 참여할 수 없지만, 친구들과 있을 수 있음*
☐ *Other 기타* _____

Recommendations for Physical Education 체육: ☐ *May participate 참여할 수 있음* ☐ *May not participate 참여하지 못함*
☐ *May participate with limitations (please describe) 제한적 참여 (설명요함):*

_____
_____
_____

Above recommendations to be in effect until (date) _____
위의 권고 사항들의 유효기간 (날짜/언제까지)

Comments/Additional Instructions: _____
소견/추가 지침

_____

Authorized Health Care Provider Signature _____
공인 의료인 서명

Authorized Health Care Provider Name (print clearly) _____
공인 의료인 이름 (정자 기입)

Telephone _____ **Date** _____
전화번호 날짜

Office Stamp

I give my permission for my child (name) 자녀이름 _____ to return to school under conditions described above. I give permission for the School Nurse to exchange health-related information with authorized health care provider.
본인은 이름 지명된 본인의 자녀가 위에서 설명한 조건 하에서 학교에 재 출석하는 것을 허락합니다. 본인은 공인 의료 공급자와 건강 관련 정보를 교환하도록 학교 간호사에 권한을 부여합니다.

Parent/Guardian Signature _____ Date _____
학부모/보호자 서명 날짜