Department of:
Health Services
Manteca Unified School District

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Authorization for Medication Administration During School Hours

In compliance with Education Code Section 49423, no medication will be accepted or administered at school without meeting the following requirements. The procedure for administration of medication by **prescription** and/or **nonprescription/Over The Counter (OTC)** medication listed on this form will be expedited as follows:

1. Only medication prescribed by the student's physician as being necessary to be taken by the student in the manner listed on this form should be brought to school. **Form must be complete and include required parent and prescribing physician signatures.**
2. Medication brought to the school to be administered to the student according to the provisions listed on this form shall be in its **original prescription container** or for nonprescription/OTC medication, in its **original manufacturers container**, clearly marked with the student's name, the prescribing physician, and the medication order: medication name, route, dosage, time/frequency, and pharmacy. (Parent may want to ask physician for a prescription for a duplicate supply; one for home and one for school).
3. **All medications will be kept in a secure place in the school office**. Any special instructions for storage or security measures of any medication should be written by the prescribing physician and delivered to the school office, so that such instructions can be followed.
4. **Parent/Guardian or adult student (18 years or older)** shall deliver the medication and the completed form to the school office. DO NOT SEND MEDICATION TO SCHOOL WITH THE STUDENT.
5. **Parent/Guardian or adult student (18 years or older)** shall pick up remaining medication during the last week of school. The school site is not responsible for medication left in the office during the summer.

If continuance of medication is necessary,

a new Authorization for Medication Administration During School Hours form

must be completed for each school year, at the beginning of the year.

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Section §49423 of the California Education Code allows students to take medications prescribed by a physician during the school day, to be assisted by designated school personnel with the medication, or to carry and self-administer ***certain*** medication when authorized in writing by the student's parent/guardian AND physician.

STUDENT INFORMATION

Student Name:_____ □Male □Female Date of Birth:_____

Current Address: _____ Current School:_____ Grade:_____

Parent / Guardian Authorization PLEASE SEE PAGE 1 FOR PRESCRIBED AND NON-PRESCRIBED MEDICATION REQUIREMENTS

In accordance with Education Code §49423 Sections (a), (b, 1, 2 &3) and (c) EC §49423.1 Sections (a), (b, 1, 2 & 3) and (c) and EC §49407, I, the undersigned parent / guardian of the above named minor student hereby authorize:

_____ School nurse or designated school personnel to **assist** my child with medication administration, monitoring, and testing
Initials according to the physician's instructions and approval below.

_____ My child to **carry and self administer:** ☐ an auto injector epinephrine pen, ☐ an asthma inhaler, or ☐ insulin and blood
Initials sugar monitoring/supplies according to the physicians instructions and approval below.

In accordance with California Education Code §49407, I hereby RELEASE, DISCHARGE, and HOLD HARMLESS the Manteca Unified School District, officers, employees and agents from all liability, including injury, death, adverse reactions, or other damages which may arise from the self administration or assisting with administration of medication according to the authorization and instructions of the undersigned parent/guardian and physician described herein.

I agree to provide the medications indicated below in original prescription containers, or original manufacturers containers, which are labeled with the name of the child, the prescribing physician, the medication, and dosage instructions. I further authorize the school nurse or designated school personnel to consult with the prescribing physician should any questions arise with regard to the medication (California Education Code §49480). **I understand that continuous medication requires annual authorization to the school's office, at the beginning of each year.**

_____ _____
Print Parent / Guardian Name Parent / Guardian Signature

_____ _____ _____
Current Address Cell Phone Work Phone

Physician Authorization THIS SECTION TO BE COMPLETED BY PRESCRIBING PHYSCIAN ONLY

Physical Condition for which medication(s) are being taken: _____

	Name of Medication	Dosage	Frequency	Route	Time of Day
#1:	_____	_____	_____	_____	_____
#2:	_____	_____	_____	_____	_____
#3:	_____	_____	_____	_____	_____

Instructions for care of student after medication administration, i.e., rest, home, hospital, doctor's office, return to class :

_____

Possible reactions after administration of medication that need to be reported to the physician: _____

Storage and other precautions:_____

Start Date: Immediate / Other Date:_____ **Stop Date**: End of Year / Other Date: _____

_____ I authorize my patient to **carry and self administer:** ☐ an auto injector epinephrine pen ☐ an asthma inhaler and/or
Initial ☐insulin and blood sugar monitoring/supplies according to my instructions and approval here stated. **I confirm that I have instructed the student in the procedures, dosages, and time schedule by which the medication is to be taken and the student is COMPETENT in self-administering the medication**. [Education Code §49423 sections (a), (b, 1,2 & 3) and (c) EC §49423.1 Sections (a), (b, 1, 2 &3) and (c)]

_____ _____ _____
Print Name of Physician Physician's Address Telephone Number

_____ _____ _____
Physician's Signature Date Fax Number

School Nurse Signature: _____ Date: _____

Site Principal Signature: _____ Date: _____

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG — Short of breath, wheezing, repetitive cough

HEART — Pale, blue, faint, weak pulse, dizzy

THROAT — Tight, hoarse, trouble breathing/ swallowing

MOUTH — Significant swelling of the tongue and/or lips

SKIN — Many hives over body, widespread redness

GUT — Repetitive vomiting, severe diarrhea

OTHER — Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE — Itchy/runny nose, sneezing

MOUTH — Itchy mouth

SKIN — A few hives, mild itch

GUT — Mild nausea/ discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

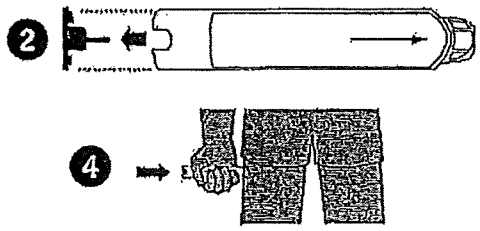
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

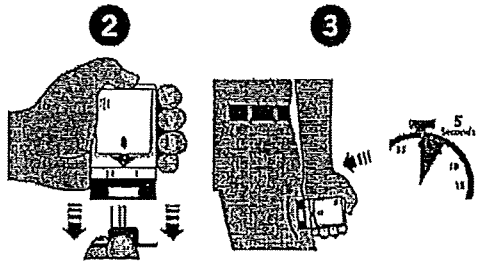
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



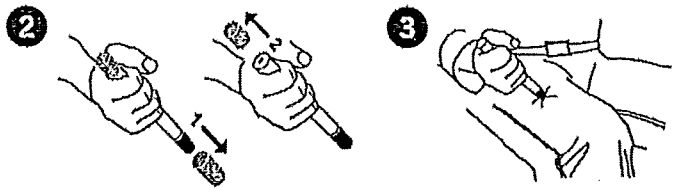
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

INSTRUCTIONS

1. **School:** Print the name of the school that is providing the form to the parent.

2. **Site:** Print the name of the school site where meals will be served.

3. **Site Phone Number:** Print the telephone number of site where meal will be served.

4. **Name of Child:** Print the name of the child to whom the information pertains.

5. **Age of Child:** Print the age of the child.

6. **Name of Parent or Guardian:** Print the name of the person requesting the child's medical statement.

7. **Phone Number:** Print the telephone number of parent or guardian.

8. **Description of Child's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child's diet.

9. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.

10. **Indicate Texture:** If the participant does not need any modification, check "Regular".

11. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified juice).

12. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).

13. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.

14. **Printed Name:** Print name of state licensed healthcare professional.

15. **Phone Number:** Telephone number of state licensed healthcare professional.

16. **Date:** Date state licensed healthcare professional signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School	2. Site Name	3. Site Phone Number
4. Name of Child		5. Age of Child
6. Name of Parent or Guardian		7. Phone Number

8. Description of Child's Physical or Mental Impairment Affected:

9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

10. Indicate Food Texture for Above Child:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

11. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Omitted	Suggested Substitutions

12. Adaptive Equipment to be Used:

13. Signature of State Licensed Healthcare Professional*	14. Printed Name	15. Phone Number	16. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.