ALBANY UNIFIED SCHOOL DISTRICT MEDICATION AUTHORIZATION

Return form to school with Parent and Health Care Provider signatures

Student Name _____ **Date of Birth**_____

Parent's Name _____ **Home Phone** _____ **Cell**_____ **Work**_____

Emergency Contact Name_____ **Home Phone** _____ **Cell**_____

When the district has received written orders from the student's physician and written permission from the parent/guardian, the school nurse or other designated personnel under supervision of the AUSD school nurse shall ***assist*** the student in taking the medication. All medication must be brought to school in an ***original container and appropriately labeled*** by the pharmacist. Parents/guardians may request that the pharmacist dispense two bottles of medication, one for home and one for school. Written permission must also be provided for students to carry and self administer prescribed medication. (CA Education Code 49423; AUSD Adiministrative Regulation 5141.21).

To Be Completed By Health Care Provider

Name of Medication or Treatment	Reason	Dosage	Route	Time	Refrigerate? (Y/N)	Self-Administer?	Self-Carry? (Y/N)
						o No o Yes, supervised o Yes, unsupervised	
						o No o Yes, supervised o Yes, unsupervised	
						o No o Yes, supervised o Yes, unsupervised	
						o No o Yes, supervised o Yes, unsupervised	

Diagnosis/Significant Findings: _____

Allergies (Medication/Other substances) _____

This Box Only Needs To Be Completed If Student Has ASTHMA

To provide assistance to a student experiencing asthma symptoms:

If you see or hear the following symptoms, follow Health Care Orders

l Noisy breathing l Coughing l Shortness of breath l Complaint of chest tightness l Difficulty breathing l Other_____

Health Care Provider Orders

1. Stay with student, speak softly, and stay calm
2. Keep student sitting upright and encourage slow deep breathing
3. Give quick relief medication Albuterol Inhaler 2 puffs **with spacer**
   Other quick relief medication:_____ Location of medication: _____
   (School to complete)
4. Have helper call guardian and school nurse
5. If symptoms do not improve, repeat in 5-10 minutes.
6. **Call 911** if you see any of the following: **Student having trouble walking or talking, stooped body posture, skin pulling in around collarbone and ribs with breathing, continuous coughing, or lips or fingernails turning gray, blue, or purple**
   May give 3-4 puffs albuterol every 20 minutes (3 times maximum) until medical help arrives.

Does student need medicine before PE or sports? o No o Yes

Albuterol Inhaler- 2 puffs with spacer, 15-20 minutes before exercise; Other quick relief medication

Health Care Provider Signature: _____ **Date:** _____

Address: _____ **Phone**:_____

To be completed by parent or guardian:

I authorize the school nurse and/or other trained school personnel to assist my child in taking his/her medications and treatments, as written above. I will notify the school immediately and submit a new form if there are changes in any of the information provided. I authorize the nurse to consult with the Health Care Provider about my child's medical needs as necessary while my child is at school.

Parent /Guardian Signature: _____ **Date:** _____