NS MT-2 CLOVIS UNIFIED SCHOOL DISTRICT

MEDICATION FOR STUDENT TRIPS/OFF-CAMPUS ACTIVITIES

Student's Name _____ Birthdate _____

Parent/Guardian Name _____

Dear Parent/Guardian/Physician:

California Education Code, Section 49423 defines certain requirements for administration of medication **"... any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which medication is to be taken, and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement."** CUSD Board Policy No. 2401 does not allow students to administer their own medication without written permission as stated above.

Additionally, CUSD Administrative Regulation No. 2401 indicates that school personnel are **prohibited** from administering any over-the-counter or prescription medications including aspirins, vitamins, antihistamines, etc. unless the medication is accompanied with **written permission from both the parent/guardian and physician.** The medication **must be** clearly labeled and sent to school in a container from the pharmacy **and will be kept in the school office unless otherwise directed by the physician.**

At the beginning of each school year or upon entry into school, a **"MEDICATION AT SCHOOL"** form must be **completely renewed.**

If you require any additional information regarding the above, please contact me at:
327-1401 (phone) OR 327-1449 (fax)

School Nurse Erin Hubbard, RN Date _____

_____

PARENT/GUARDIAN REQUEST

We, the undersigned, who are the parents/guardian of _____ request that the school nurse or designated school personnel assist our child in the matter set forth by the physician's statement. In the event of an untoward or subsequent reaction, it is understood that the school personnel will in no way be held responsible for carrying out this request.

Signature of Parent/Guardian _____ Date _____

PHYSICIAN MUST COMPLETE THE REVERSE SIDE OF THIS FORM

PHYSICIAN'S ORDERS

Student's Name_____

1. Medication is needed for the following reason(s):_____

_____

NAME OF MEDICATION	DOSAGE	TIMES TO BE GIVEN

2. Time limit on medication (i.e., 10 days, 1 month, etc.):_____

3. Student may carry inhaler on his/her person Yes___ No____

PERMISSION TO GIVE OVER-THE-COUNTER MEDICATION

During school trips and/or when student is participating in an off-campus activity, he/she may take the following:

YES	NO	MEDICATION	DOSAGE	TIME(S) TO BE GIVEN
☐	☐	Tylenol (325mg)	2 tablets	every 4 hrs if needed for pain/fever
☐	☐	Benadryl (25mg)	1-2 tablets	every 4-6 hrs if needed for sneezing, itching, runny nose
☐	☐	Tums	1-2 tablets	for upset stomach, heartburn as needed
☐	☐	Dramamine (50mg)	1-2 tablets	every 4 hrs if needed for motion sickness
☐	☐	Ibuprofen (200mg)	1-2 tablets	every 4 hrs if needed for pain/fever
☐	☐	Bacitracin Ointment	As needed	1-3 times daily on affected areas
☐	☐	Sudafed (30mg)	1 tablet	every 4-6 hrs if needed for congestion

Physician's Name (please print or type)_____

Physician's Signature_____ Date_____

Address_____ Phone_____

THANK YOU!