Medication Guidelines

CCR Title 5 regulations on Administering Medication to Students During the School Day as pursuant to the California State Board of Education Code Section 49423.6:

1. All medication, including over-the-counter medications, must be delivered in the original pharmacy-labeled or manufacturer’s container by a parent or adult designee.

2. The Authorization for Medications to be Taken During School Hours form must be completed by a parent and the child’s physician, then submitted to the health office when the medication is brought to school. This form can be found at the www.lyusd.org

Click on Parents at the top
Scroll down to Other Resources & Information
Click on Student Health Information
Click on School Health Forms

3. Students may not carry medication in their backpack (except inhalers, epinephrine auto injector, glucagon or Diastat). Medications such as Advil, vitamins, herbal supplements must be left in the health office and require the Authorization for Medications to be Taken During School Hours form to be completed by both the parent and physician.

4. Instructions on administering medications must include the dosage, frequency, and time of administration. Instructions to “follow package directions” will not be accepted.

5. Medications that are controlled substances, such as Ritalin and Adderall, will be counted and documented when delivered to the health office. Refills brought to the school must be delivered in a pharmacy labeled container by parent or adult designee.

6. If the date on any medication is expired or the prescription is more than one year old, the medication will not be accepted.

7. For the health and safety of all students, medications are not to be sent with students. A parent, or adult designee, is required to deliver and pick up medications from the health office.

Rev: 2.2018
**AUTHORIZATION FOR MEDICATIONS TAKEN DURING SCHOOL HOURS, SCHOOL ACTIVITIES AND FIELD TRIPS**

Valid *only* for the current school year or as designated in the Individual Education Program (IEP) or in the 504 Plan.

**Exception:** California Education Code 49423.5, specialized services, i.e., EpiPen, nebulizer, glucagon, insulin, diabetes care, etc., may require additional forms and instructions signed by parent or legal guardian and physician. Request *Specialized Services* forms from school.

### 1. Parent or Legal Guardian Section

**Note:** All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child’s name, name of the medication, dosage, method of administration, time schedule and name of physician. Please refer to Legal References Governing the Administration of Medication in Schools on the reverse side of this form.

I request that designated unlicensed, trained school staff or licensed nurse assist my child in taking this prescribed medication(s) (including prescribed over-the-counter medication). I understand that my child may not be assisted with medication at school until all requirements are met. I hereby give consent for a school nurse (or designee) to communicate with my child’s prescriber and to counsel school personnel as needed with regard to my child’s health. I agree to, and do hereby hold the District and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this medication. I agree to comply with district rules related to administering medication at school.

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>M</th>
<th>F</th>
<th>Birth Date</th>
<th>Student Identification Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of School</td>
<td></td>
<td></td>
<td>Grade</td>
<td>Teacher/Room Number</td>
</tr>
<tr>
<td>List all medications routinely taken <strong>outside</strong> of school hours:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will <strong>immediately</strong> notify the school if there are any changes in medications my child is taking at school.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature of Parent or Legal Guardian</td>
<td>Date</td>
<td>Home/Mobile Telephone</td>
<td>Work Telephone</td>
<td></td>
</tr>
</tbody>
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### 2. Physician Section

The child named above is under my care for these diagnoses:

It is necessary for him or her to receive the following prescribed medication(s) during schools hours.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage (be specific, i.e. milligrams, etc.)</th>
<th>Frequency and Indication if “as needed”</th>
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</thead>
<tbody>
<tr>
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<td>Frequency and Indication if “as needed”</td>
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<td>Precautions or side effects</td>
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Storage and handling
- [ ] Routine handling, medication in locked storage and administered by authorized school personnel
- [ ] On-site 72 hour disaster supply only
- [ ] It is Medical Necessity for child to carry prescription for asthma, anaphylactic shock or diabetes, and indicate:
  - [ ] Designated school personnel to administer
  - [ ] Child trained to self-administer

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Signature of Physician

<table>
<thead>
<tr>
<th>Date</th>
<th>Stamp physician name/address below:</th>
</tr>
</thead>
</table>

Name of Physician (please print) | License Number | Office telephone |


White – School District
Canary – Parent or Legal Guardian
Pink – Physician or Licensed Health Care Provider

SFA 5030, Rev. 3/18/2014
**FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN**

Name: ___________________________  
D.O.B.: __________________________

Allergy to: ____________________

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

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

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**Extremely reactive to the following allergens:**

**THEREFORE:**

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

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

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### FOR ANY OF THE FOLLOWING: SEVERE SYMPTOMS

<table>
<thead>
<tr>
<th>LUNG</th>
<th>HEART</th>
<th>THROAT</th>
<th>MOUTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of breath, wheezing, repetitive cough</td>
<td>Pale or bluish skin, faintness, weak pulse, dizziness</td>
<td>Tight or hoarse throat, trouble breathing or swallowing</td>
<td>Significant swelling of the tongue or lips</td>
</tr>
</tbody>
</table>

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<tr>
<th>SKIN</th>
<th>GUT</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many hives over body, widespread redness</td>
<td>Repetitive vomiting, severe diarrhea</td>
<td>Feeling something bad is about to happen, anxiety, confusion</td>
</tr>
</tbody>
</table>

**OR A COMBINATION of symptoms from different body areas.**

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1. **INJECT EPINEPHRINE IMMEDIATELY.**

2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders 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 patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

### MILD SYMPTOMS

<table>
<thead>
<tr>
<th>NOSE</th>
<th>MOUTH</th>
<th>SKIN</th>
<th>GUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itchy or runny nose, sneezing</td>
<td>Itchy mouth</td>
<td>A few hives, mild itch</td>
<td>Mild nausea or discomfort</td>
</tr>
</tbody>
</table>

**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 or Generic:**

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

**Antihistamine Brand or Generic:**

Antihistamine Dose: ____________________

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

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**FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 3/2018**

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE  
DATE  
PHYSICIAN/ACP AUTHORIZATION SIGNATURE  
DATE