DIXON UNIFIED SCHOOL DISTRICT

Anderson Elementary	Tremont Elementary	CA Jacobs Intermediate	Dixon High School	Maine Prairie	Gretchen Higgins
415 East C Street	355 Pheasant Run	200 North Lincoln	555 College Way	305 East C Street	1525 Pembroke
Dixon CA 95620	Dixon CA 95620	Dixon CA 95620	Dixon CA 95620	Dixon CA 95620	Dixon CA 95620
Phone:707-678-5508	Phone:707-678-9533	Phone:707-678-9222	Phone: 707-678-2391	Phone: 707-678-4560	Phone: 707-678-6271
FAX 707-678-2073	FAX 707-678-0298	FAX 707-678-1245	FAX 707-678-9318	FAX 707-678-4890	FAX: 707-693-1960

Student: _____ Date: _____

PUPIL SELF-ADMINISTRATION OF MEDICATION

A student may carry and self-administer asthma inhalers and auto-injectable epinephrine medications if all of the following conditions are met (Ed Code 49423).

Physician's Authorization:

The above named student has my authorization to carry and self-administer the following:

Medication: _____ Dosage: _____

Reason for the prescription: _____

Medication is to be used under the following conditions: _____

Due to the life threatening circumstances that could result if this individual does not have immediate access to this medication, as a physician I am requesting that this student be allowed to carry and self-administer this medication. I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication on his own without school personnel supervision.

Physician's signature: _____ Date:_____

Physician's name: _____ Phone: _____

Parent/Guardian Authorization:

I confirm that this student has been instructed by his/her doctor on the proper use of this medication. He/she is physically, mentally and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate if needed. If he/she has used auto-injectable epinephrine, he/she understands that he/she needs to alert an adult that an emergency medical technician needs to be called. If he/she has used his/her asthma inhaler as prescribed and does not have relief from an asthma attack, he/she is to alert an adult.

I give permission for the district nurse or other designated school personnel to consult with the doctor regarding any questions about this authorization. I also release the school district and school personnel from civil liability if the pupil suffers any adverse reaction from self-medicating.

Discipline Clause:

It is vitally important that the medication being carried by the student is used only by the authorized student, and as prescribed by the student's physician. If the student knowingly uses the medication other than as prescribed of for purposes other than the diagnosed illness, or should the child knowingly give the medication to another student, or should the authorized child lose their medication or have someone take it from them, and not report this to the school office immediately; the authorized student will be subject to disciplinary measures up to and including suspension or expulsion from school.

Parent/guardian Signature_____ Student Signature _____

This form must be completed in addition to the routine district medication authorization form.

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Alumno:_____ Fecha:_____

AUTO-ADMINISTRACION DE MEDICAMENTOS DEL ALUMNO

El estudiante puede tener consigo la administracion de inhaladores tambien la administracion de epinepfrina auto-injectable si las siguientes condiciones son cumplidas Codigo de educacion (49423).

Physician's Authorization:

The above named student has my authorization to carry and self-administer the following:

Medication: _____ Dosage: _____

Reason for the prescription: _____

Medication is to be used under the following conditions: _____

Due to the life threatening circumstances that could result if this individual does not have immediate access to this medication, as a physician I am requesting that this student be allowed to carry and self-administer this medication. I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication on his own without school personnel supervision.

Physician's signature: _____ Date:_____

Physician's name: _____ Phone: _____

Autorizacion de Padre o Guardian:

Yo confirm que el estudiante ha sido instruido por su doctor en el uso apropiado de este medicamento. El/Ella esta fisicamente, emocionalmente capaz y en condiciones de asumir esta responsabilidad. El/Ella tiene mi permiso para auto-administrarse el medicamento si es necesario. Si el/ellaha usado la epinefrina auto-injectable, el/ella entiende que debe de informar a un adulto y el equipo de emergencia necesita ser notificado. Si El/Ella ha usado un inhalador para el asma como fue prescribido y no tiene alivio en un ataque de asma, El/Ella necesita alertar a un adulto.

Yo doy permiso a la enfermera del distrito u otro personal designado para consultar con el doctor con respect a a cualquier pregunta acerca de esta autorizacion. Yo tambien libero al distrito y personal escolar de cualquier responsabilidad civil si el estudiante sufre cualquier reaccion adversa de esta auto-administracion de medicamento.

Clausula Disciplinaria:

Es vitalmente importante que el medicamento que el estudiante lleva consigo sea solamente usado por el estudiante autorizado y como lo indica el medico. Si el estudiante a sabiendas usa este medicamento de otra manera como lo autorizo el medico, o si El/la estudiante a sabiendas le da el medicamento a otro estudiante, lo pierde y otro estudiante lo toma y no reporta esto a la oficina escolar inmediatamente; el estudiante autorizado sera sujeto a medidas disciplinarias y pueden incluir hasta la suspension y expulsion de la escuela.

Firma del Padre/Tutor_____Firma de Alumno_____

Esta forma debe completarse en adición de la forma de rutina de Autorización de Medicamentos del distrito.