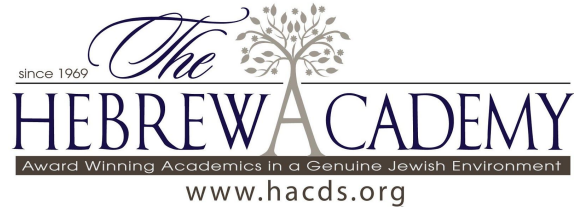


SCHOOL ASSISTED MEDICATIONS

Physician Instructions and Parent Request

This form must be completed before any medication (*prescription or over-the-counter*) can be given, or taken, at school.

Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.



Student Name: _____ Date of Birth: _____

| PHYSICIAN USE ONLY | |
|---|--|
| 1. MEDICATION: _____ | Dose: _____ Reason/Diagnosis: _____ |
| Route: <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Topical <input type="checkbox"/> Inhale <input type="checkbox"/> Injection <input type="checkbox"/> Other _____ | Med Start Date: _____ Stop Date: _____ |
| <input type="checkbox"/> If DAILY ~ Time(s) to be given: _____ | |
| <input type="checkbox"/> If AS NEEDED (prm) ~ Frequency: <input type="checkbox"/> Every 3 to 4 hrs., <input type="checkbox"/> Every 4 to 6 hrs., <input type="checkbox"/> Other _____ | |
| Other instructions, if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____ | |
| <hr/> | |
| 2. MEDICATION: _____ | Dose: _____ Reason/Diagnosis: _____ |
| Route: <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Topical <input type="checkbox"/> Inhale <input type="checkbox"/> Injection <input type="checkbox"/> Other _____ | Med Start Date: _____ Stop Date: _____ |
| <input type="checkbox"/> If DAILY ~ Time(s) to be given: _____ | |
| <input type="checkbox"/> If AS NEEDED (prm) ~ Frequency: <input type="checkbox"/> Every 3 to 4 hrs., <input type="checkbox"/> Every 4 to 6 hrs., <input type="checkbox"/> Other _____ | |
| Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____ | |
| <hr/> | |
| Physician Signature: _____ | Date: _____ |
| Physician Name: _____ | |
| Address: _____ | Phone: _____ |
| City: _____ | Zip: _____ |

Parent Request for School-Assistance with Medication

I/we hereby request that the staff of the Hebrew Academy of Huntington Beach assist with giving medication(s) to my/our child _____ (student's name) as stated in the above physician instructions. **I/we also give permission to contact the physician for consultation and exchange of information as needed.**

Release of Liability and Agreement to Indemnify and Hold School Harmless (must be completed)

I/we hereby expressly release, hold harmless, and agree to indemnify and defend the Hebrew Academy of Huntington Beach and its Governing Board members, officers, employees, agents, representatives, independent contractors and insurers (collectively referred to as the "School") from all claims and liability for any personal injuries, death, or property damage that may be incurred by permitting the school to assist in the giving my child's medication. This release, hold harmless and indemnification agreement shall remain in effect until the written notice to terminate the agreement is received and acknowledged in writing by the school principal. I/we understand and agree that if I/we terminate this agreement, the school will no longer assist in giving medication to my child.

I/we understand that school regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school and not carried on the person of a student. (Some emergency medications may be self-carried with written physician instructions and compliance with school policies. See accompanying information on self-carrying of medications.)

I/ we give the school permission to contact my/our child's physician and inform school personnel regarding possible side effects of the drug on my/our child's physical, intellectual, and social behavior as well as signs and symptoms of side effects, omission, or overdose.

| | | | |
|---------------------------------|--------------|--------------|---------------------------------|
| () | () | () | () |
| Signature of Parent or Guardian | Date | Phone Number | Signature of Parent or Guardian |
| Date | Phone Number | Date | Phone Number |

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

California Education Code section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for him 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 such 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 matters set forth in the physician's statement.