

MEDICATION FOR STUDENT TRIPS/OFF-CAMPUS ACTIVITIES

Student's Name _____ Birthdate _____

Dear Parent/Guardian:

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 the permission slips 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 for Student Trips/Off Campus Activities" form must be **completely renewed.**

If you have any additional questions or concerns regarding the above information, please do not hesitate to contact the School Nurse at _____ FAX _____

School Nurse _____ Date _____

School: _____

PARENT/GUARDIAN REQUEST

We, the undersigned, who are the parents/guardian of _____ request that the school nurse or other designated school personnel assist our student in the matter set forth by the physician's statement. In the event of an untoward or subsequent reaction, it is understood that 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 Name _____ School _____

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

<u>NAME OF PRESCRIPTION MEDICATIONS</u>	<u>DOSAGE</u>	<u>TIME(S) TO BE GIVEN</u>

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

3. Student may carry medication on his/her person (**must be** age appropriate) Yes _____ No _____

APPROVED OVER-THE-COUNTER (OTC) MEDICATIONS

The following OTC medications are approved to be administered to students with written permission from their parent/guardian and physician. Dosages for the OTC medications are not to exceed the manufacturer’s recommendations unless otherwise specified by the student’s physician. **All OTC medications should be supplied by the student’s parent/guardian.**

Pain and fever:

- Ibuprofen (i.e. Advil, Motrin, store brands, generic)
- Acetaminophen (i.e. Tylenol, store brands, generic)
- Naproxen (i.e. Aleve, store brands, generic)

Allergy/Antihistamines:

- Diphenhydramine Hydrochloride (i.e. Benadryl, store brands, generic)
- Dimenhydrinate (i.e. Dramamine)
- Loratadine (i.e. Zyrtec, Claritin, store brands, generic)
- Tear substitute (i.e. HypoTears, Murine Tears, Refresh Eyes, store brands, generic)
- Anti-allergy eye drops (i.e. Visine-A, Naphcon, Ophcon-A, Zaditor, store brands, generic)

Antacid:

- Calcium Carbonate (i.e. Pepto for Kids, Tums, store brands, generic)
- Aluminum Hydroxide and Magnesium Hydroxide (i.e. Mylanta, Maalox, store brands, generic)

Topical:

- Pramoxine/Camphor/Calamine (Caladryl, store brands, generic)
- Neomycin/Polymyxin (i.e. Neosporin, store brands, generic)
- Hydrocortisone (i.e. Aquanil HC, Caldecort, Cetacort, Cortaid, Hycort, store brands, generic)

Colds:

- Chlorpheniramine/Phenylpropanalamine (i.e. Triaminic, store brands, generic)
- Brompheniramine (i.e. Dimetapp, store brands, generic)
- Chlorpheniramine (i.e. Pediacare, Vicks44m Pediatric, store brands, generic)
- Dextromethorphan (i.e. Robitussin CF, Sucrets, store brands, generic)
- Non-medicated cough drops (parent’s choice)

Other OTC meds– please specify: _____

Physician's Name (please print or type) _____

Physician's Signature _____ Date _____

Physician’s Address _____ Phone _____