

**Carlsbad Unified School District
Medical Packet - 2017**

Medication at school

The following forms must be completely filled out and signed by parents. Please note that some forms require information & signatures of medical personnel. Some forms are optional and are indicated as such below.

HS-39e HIPAA Form

Authorization For Use Or Disclosure Of Health Information To And From Schools

HS-36e Waiver Form

Parent Waiver of School Responsibility

HS-53b Authorization for Medication

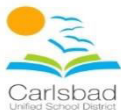
Authorization for Medication Administration

HS-57e Self Carry/Administer (If Needed)

Authorization For Self-Carry/Administration Of Medicine/Insulin At School

----- School Use Only -----

Completed Packet Received by: _____ Date Received: _____



Carlsbad Unified School District

Health Services Department • 3557 Monroe Way • Carlsbad, California 92008 • 760/331.5265 • FAX 760/720.3828

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO and FROM SCHOOLS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal laws. (e.g., **HIPAA**) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ / _____ / _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of health care provider, health plan and/or agency):

(1) _____ () _____ (2) _____ () _____
(Please print) Physician's Name Phone Physician's Name Phone

To provide health information from the above-named child's medical record to and from:

Carlsbad Unified School District • 3557 Monroe Way • Carlsbad, CA 92008

School District to Which Disclosure is Made

Address/City and State/ Zip Code

Julia Hart-Lawson RN, MA (760) 331.5265

Howard Taras M.D. 619/681.0665

District School Nurse • Contact Person at School District

Medical Consultant for School District

Disclosure of health information is required for the following purpose: _____

Requested information shall be limited to the following: All minimum necessary health information; or Disease-specific information as described: _____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ / _____ / _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS: California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

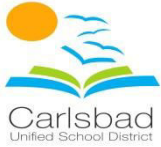
YOUR RIGHTS: I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE: I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL: _____ / _____ / _____
Printed Name Signature Date

Relationship to Patient/Student () Area Code and Telephone Number



CARLSBAD UNIFIED SCHOOL DISTRICT
Health Services Department

SPECIALIZED PHYSICAL HEALTH CARE SERVICES
Parent Waiver of School Responsibility

Name of Student	Date of Birth
Diagnosis	School
Specified Physical Health Care Services	Date Prescribed
Name of Parent or Legal Guardian	Relationship to Pupil
Address of Parent of Legal Guardian	Telephone
Reason(s) for Request of Waiver	
Comments (School Personnel Use)	
Estimated Period of Time Service May be Necessary	
Date(s) for Review of Service	
<p>CALIFORNIA ADMINISTRATIVE CODE, TITLE 5, SECTION 3051.12, provides that when a parent elects to perform or have non-district personnel perform a Specialized Physical Health Care Service in a school program, a waiver shall be signed by the parent relieving the school district from any and all responsibility related to delivery of such specialized service when non-district personnel provide this service. This waiver also applies to students who have been given responsibility to perform such services. This may include self-medication as prescribed.</p>	
<p>WE (I) as parent(s) of student named above hereby elect to have the above specified health services or medications, performed/administered by ourselves, by the student him/herself, or by non-district personnel on the school site during regular school hours. Furthermore, in electing to provide such service, we (I) agree to hold Carlsbad Unified Schools and its employees free from any and all responsibility for such service or the manner in which it is administered.</p>	
Signature of Parent or Legal Guardian	Date Signed



CARLSBAD UNIFIED SCHOOL DISTRICT
HEALTH SERVICES
El Distrito Unificado Escolar de Carlsbad Servicios de Salud

AUTHORIZATION FOR MEDICATION ADMINISTRATION (Education Code Section 49423)
Autorización para la Administración de Medicamentos (Código de Educación Sección 49423)

This form is valid for school year _____ to _____ only.
Este formulario es válido para el año escolar _____ a _____ solamente

I, the undersigned, as legal parent/guardian of _____
El abajo firmante, como padre/guardian de

birthdate _____ attending _____ school request that the following
fecha de nacimiento Asistiendo a la escuela require que los siguientes medicamento(s)

medicine(s) _____ be made available to my child at the times
eesten disponibles para mi hijo durante las horas prescritas
prescribed _____

I understand that only personnel authorized by the school will assist my child in taking the medicine(s) as directed by my physician. *Entiendo que solo el personal autorizado por la escuela ayudará a mi hijo a tomar el medicamento(s) según las indicaciones de mi médico.*

I will provide the medicine(s) **in the prescription container(s)**, which is/are labeled with the name of my child, the prescribing physician name, and amount of medication prescribed.. *Proveeré la(s) medicina(s) en el (los) recipiente (s) con receta, la(s) cual(es) lleva(n) el nombre de mi hijo(a), en la etiqueta, el nombre del médico que prescribe, y la cantidad de medicamentos prescritos.*

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician. *Si el médico cambia cualquiera de las condiciones en la declaración, será necesario llenar un Nuevo formulario firmado por el padre/tutor legal y el médico.*

Prescription and nonprescription medications are not permitted to be taken at school without a written statement from the physician **and** a written statement from the parent indicating desire that the district assist the student as set forth in the physician's statement below. *No se permite consumir medicamentos con o sin receta en la escuela sin una declaración escrita por el médico y una declaración por escrito del padre indicando que el distrito asista al estudiante como se establece en la declaración del médico a continuación.*

Signature _____ Date _____
Firma Fecha

Home Address _____ Work telephone _____ Home telephone _____
Dirección Teléfonos del trabajo Teléfonos de casa

This portion to be completed by a physician licensed in the State of California.

	Name of Medication	Method of Administration	Dosage	Approx. Time of Day
#1	_____	_____	_____	_____
#2	_____	_____	_____	_____

2. Discontinue Medication #1 on _____ and Medication #2 on _____
3. Diagnosis _____ Reason for giving medication _____
4. Type of Assistance for Administering Medication (Observe, measure, etc.) _____
5. Precautions for Administration or Storage of Medication _____

6. Do you wish to have school personnel contact you at intervals to discuss this medication: Yes No
Please indicate: Person(s) _____ Intervals _____

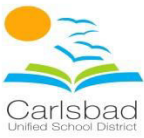
(Teacher/Resource Nurse _____ Daily, Weekly, Quarterly, etc.)
M.D. _____

Printed Name of Physician _____ Medical License Number _____ Telephone Number _____

Signature of Physician _____ Date _____

The Procedure covering prescription and **nonprescription** medication listed on this form will be expedited under the following conditions: *El procedimiento que cubre medicamentos con o sin receta mencionados en este formulario serán processados inmediatamente bajo las siguientes condiciones.*

1. Only medication prescribed by the pupil's physician as being necessary to be taken by the pupil in the manner listed on this form should be brought to school. (Written parent permission also required.) *Sólo los medicamentos prescritos por el medico del alumno como necesarios para ser tomados por el alumno en la manera indicada en este formulario debe ser traído a la escuela (También se requiere un permiso por escrito del padre.)*
2. Such medication should be taken by the pupil in accordance with instruction from the physician as listed on this form. *Tal medicamento debe ser tomada por el alumno de acuerdo a las instrucciones del medico como se indica en este formulario.*
3. Medication brought to school to be given to the pupil according to the provisions listed on this form should be in its **prescription containers** which are clearly marked with the name of the pupil; the name of the prescribing physician; the druggist who dispensed the medication or the manufacturer; and the amount of the medication to be taken at specified times or in specific situations, etc. (Parents may want to ask the physician for a prescription for a duplicate supply, one for home and one for school.) *Los medicamentos traídos a la escuela que deben dars al alumno de acuerdo con las provisiones mencionadas en este formulario deben estar en sus envases con receta y claramente marcados con el nombre del alumno; el nombre del medico que prescribe; el nombre del farmacéutico que dispensa los medicamentos; y la cantidad del medicamento asi como las horas o en situaciones especificas, etc. (Los padres pueden pedirle al medico que duplique la prescription para un suministro, uno para el hogar y otro para la escuela)*
4. All medication will be kept in a secure place. Any special instructions for storage or security measures of any medication should be written by the physician and given to school personnel so that such instructions can be followed. *Todos los medicamentos se mantendran en un lugar seguro. Cualquier instucción especial de como guardar o medidas de seguridad de cualquier medicamento deben ser escritas por el medico y deben dars al personal escolar para que dichas insturcciones se pueden seguir.*
5. Parent or **designated adult** shall deliver the medication **and** the completed form to the school health office. *El padre o adulto designado deberá entregar el medicamento y el formulario complete a la oficina de salud de la escuela.*
6. A new medication authorization must be renewed for each **school** year if a continuance of medication is necessary. *Una nueva autorización de medicamento debe ser renovado para cada año escolar si es necesario continuar el medicamento.*
7. Controlled substances will be counted and signed for by health technician and person delivering the medication. *Las sustancias controladas serán contadas y firmadas por un técnico de salud y la persona que entrega el medicamento.*
8. When a physician prescribes over-the-counter or non-prescription medication, it should be kept in its original container. *Cuando un medico prescribe medicamentos sin receta, debe de permanecer en su envase original.*
9. Homeopathic medicines, herbs, and vitamins require a medical authorization form completed by your physician. *Los medicamentos homeopáticos, hierbas y vitaminas requieren un formulario de autorización médica completada por su medico.*



CARLSBAD UNIFIED SCHOOL DISTRICT
Health Services Department

AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF
MEDICINE/INSULIN AT SCHOOL (Gr. 6-12)

School Year _____ - _____ School Site: _____

Student: _____ Date of Birth: _____ Grade: _____

Diagnosis: _____ Parent/Guardian Telephone: () _____

Medication: _____ Dose: _____ Time: _____

Medication: _____ Dose: _____ Time: _____

Medication is permitted in accord with district policy. Note: due to safety concerns each student is individually evaluated based on their health condition and developmental level. Best practice guidelines recommend a California Licensed Health Care Provider authorization for self-administration of medication.

Responsibilities for Carrying Medication: (please check off and fill in the blanks)

Parent Student Physician

- Medication must be in its original container with current pharmacy label
Student recognizes proper and prescribed timing for medication (per above)
Student agrees to never share medication with others
Student demonstrates to parents/physician/health tech correct use/administration
Student keeps medication in agreed location:
Student agrees to come directly to the health Office if having any adverse symptoms
Parent informs nurse of change in diagnosis or medication
Medication must be in its original container with current pharmacy label

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER
THE ABOVE MEDICATION.

Care Provider Signature Print Name Telephone License # Date

I request that my child, named above, be permitted to carry and self-administer the above ordered medication. I take personal responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescription CA Licensed Health Professional, and medication; date of original prescription, strength and dose of medication; and directions for use. I will support my child to follow the above agreement and if she/he does not, I will be contacted and we will develop a new plan. I RECOGNIZE THAT THE SCHOOL WILL NOT BE ABLE TO TRACK COMPLIANCE WITH THE MEDICATION DOSING SCHEDULE. It will be my responsibility to ensure compliance. As a parent/guardian of the student, I agree to hold harmless and indemnify the school and Carlsbad Unified School District's officers, employees and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by their student.

Parent/Guardian Signature Date Student Signature Date