Medication Administration Assistance
Parent Information

If your child needs to take medications of any kind (prescription or over the counter) during the school day or during field trips:

> An **Authorization for Medication form, Asthma Action Plan, Diabetes Management Plan, Seizure Action Plan, and/or Severe Allergy Action Plan** must be received, completed by the student's physician with written permission from the parent/guardian. Once the forms are received, the school nurse or other designated personnel (under supervision of the OUSD school nurse) will assist the student in taking the medication.

In addition, please keep in mind and comply with the following information:

1. Talk to your child's doctor about a medicine schedule that does not require your child to take medicine while at school.

2. If your child must take medicine while at school or on field trips, all appropriate forms authorizing medication use during school hours must be completed by you **and** your child's doctor or other health care provider. The forms are available at each school site. Please provide new, updated forms at the beginning of each school year **and** whenever there is any change in the medicine, instructions, or doctor (*EC* Section 49423).

3. As parent or guardian, you must supply the school with all medicine your child must take during the school day or on field trips. Parents/guardians may request that the pharmacist dispense two bottles of medication, one for home and one for school. You or another **adult** must deliver the medicine to school, except medicine your child is authorized to carry and take by him or herself.

4. All controlled medicine, like Ritalin, must be counted and recorded on a medicine log when delivered to the school. You or another adult who delivered the medicine should verify the count by signing the medication check-off list.

5. All medicine must be brought to school in the **original container** and **appropriately labeled by the pharmacist.** Each medicine your child takes at school must be in a separate container labeled by a pharmacist licensed in the United States. The container must list your child's name, doctor's name, name of the medicine, and instructions for when to take the medicine and how much to take.

6. Pick up all discontinued, outdated, and/or unused medicine before the end of the school year.

7. Parents are encouraged to view the OUSD medication policy (BP 5141.21) at www.ousd.org

OAKLAND UNIFIED SCHOOL DISTRICT

Asthma Action Plan

Expiration date:_____

Student Name _____ Date of Birth _____ ID# _____

School _____ School Phone _____

Parent/Guardian Name _____ Parent/Guardian Phone _____

Emergency Contact Name _____ Emergency Contact Phone _____

Healthcare Provider Name _____ Health care Provider Phone _____

Attention Parent/Guardian/School Personnel: ANY student with asthma (any severity) can have a SEVERE asthma attack.

Asthma is triggered by: ☐ Exercise ☐ Cold Air ☐ Animal Dander ☐ Strong Odors ☐ Grass/Pollen ☐ Colds/Flu ☐ Mold ☐ Other

Controller Medicines at home	How Much to Take	How Often	Other instructions
		_____ time(s) per day EVERY DAY!	Gargle or rinse mouth after use

▶ If student does not have any medication at school, notify parent immediately. Call 911 if symptoms persist longer than 10 minutes.

SPECIAL INSTRUCTIONS: WHEN I AM ☺ doing well, 😐 getting worse, ☹ having a medical alert

I Feel Good (Green Zone)

- Breathing is good, and
- No cough, wheeze, chest tightness, or shortness of breath During the day or night, and
- Can work or play as normal.
- **Peak Flow** (for age 5 and up):

_____ to _____(80% - 100% of personal best)

Personal Best Peak Flow is _____

PREVENT asthma symptoms every day:

☐ Take my controller medicines (above) every day at home as prescribed

☐ Before exercise, take _____ puff(s) of _____ with spacer (if available) 10 minutes before exercise

I Don't Feel Good (Yellow Zone)

- Cough, wheeze, chest tightness, or shortness of breath, or can do some, but not all usual activities.
- Waking at night due to asthma symptoms.

Watch for Red Zone symptoms.

- **Peak Flow** (for age 5 and up):

_____ to _____(50% - 79% of personal best)

***CAUTION*, continue taking every day controller medicines at home, AND:**

Begin QUICK RELIEF medication right NOW

- Take _____ puffs of _____ with spacer (if available).
- Wait 15 – 20 minutes. If symptoms are not better, repeat the above dose and wait another 15 minutes.
- If symptoms return to GREEN ZONE wait for 15 minutes.
- If symptoms remain in the Green Zone, return to class and continue using quick relief medicine _____ puffs every _____ hours as needed.

▶ If ***NOT*** back in the Green Zone after the second dose of medicine, **GO TO THE RED ZONE**

Medical Alert (Red Zone)

- Severe chest tightness, or
- Very short of breath or uncontrolled cough, or
- Nose opens wide or ribs show with breath, or
- Quick relief medicine has not helped, or
- Trouble talking or walking, or
- Blue lips or fingernails, or drowsy or confused

Peak Flow (for age 5 and up) under _____ 50% of personal best)

***EMERGENCY*! Get help! Do not leave student alone!**

Take ☐ 4 or ☐ 6 puff of _____ with spacer (if available).

Repeat every 10 – 15 minutes until paramedics arrive.

▶ **Call 911 immediately and call Parent/Guardian**

Health Care Provider: My signature provides authorization for the above written order. I understand that all procedures will be implemented in accordance with state laws and regulations.

Student carry and self-administer asthma medications: ☐ **Yes** ☐ **No**

Print Provider Name/Credentials: _____ Signature _____ Date _____

This authorization is valid for one year from signature date.

Parent Request and Authorization: I request that the school assist my child with the above asthma medication(s) and the Asthma Action Plan as ordered by the health care provider in accordance with state laws and regulations. I understand that the medication must have a pharmacy label with the name of the student and the health care provider. I give permission for the school nurse to communicate with the healthcare provider on matters related to this Asthma Action Plan.

My child may carry and self-administer asthma medications: ☐ **Yes** ☐ **No**

Print Parent Name: _____ Signature _____ Date _____

Adapted with permission from Regional Asthma Management and Prevention (RAMP), a program of the Public Health Institute, for use by Oakland Unified School District, Health Services

School Nurse: _____ Signature _____ Date _____

OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

Credentialed School Nurse Use Only

Orders expiration date
Medication expiration date_____

_____

Authorization for Medication

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____ Room: _____

The California Education Code relating to the giving of medications at school states:

49423, Notwithstanding the provisions of Section 49422, any student who is required to take, during the regular school day, medication prescribed for him/her by a healthcare provider, may be **assisted** by the school nurse or other designated school personnel if the school district receives (1.) a written statement from such provider 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 student indicating the desire that the school district assist the student in the matter set forth in the provider's statement.

TO BE COMPLETED BY A LICENSED PROVIDER

Name of Medication (generic and brand)	Reason for Medication	Route	Dosage	Time	Self-Administer	Self-Carry
1.					□ No □ Yes, supervised □ Yes, unsupervised	☐ No ☐ Yes
2.					□ No □ Yes, supervised □ Yes, unsupervised	☐ No ☐ Yes
3.					□ No □ Yes, supervised □ Yes, unsupervised	☐ No ☐ Yes

Please Note:

- **All medication must be brought to school in an original container and appropriately labeled by the pharmacist.**
- **School Nurse and prescribing provider may communicate to clarify matters related to this medication.**
- **New orders are required annually and for any changes in medication regimen.**

Provider's Name (Please Print): _____ **Phone:** _____

License No.: _____ **NPI No.:** _____

Provider's Signature: _____ **Date:** _____

I request that the school nurse, or other person designated by the principal, administer the medication as directed by the physician:

Parent/Guardian Name (Please Print): _____ **Phone:** _____

Signature: _____ **Date:** _____

Reviewed by (Name of School Nurse): _____ **Phone:** _____

Signature of School Nurse: _____ **Date:** _____

Revised: 8/9/18

Student's Last Name

School

Allergy to: _____

Extremely reactive to the following

THEREFORE:

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. SCHOOL/AGENCY	2. SITE	3. SITE TELEPHONE NUMBER

4. NAME OF PARTICIPANT	5. AGE OR DATE OF BIRTH

6. NAME OF PARENT OR GUARDIAN	7. TELEPHONE NUMBER

8. CHECK ONE:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician must sign this form.**

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, or registered nurse must sign this form.**

9. DISABILITY OR MEDICAL CONDITION REQUIRING A SPECIAL MEAL OR ACCOMMODATION:

10. IF PARTICIPANT HAS A DISABILITY, PROVIDE A BRIEF DESCRIPTION OF PARTICIPANT'S MAJOR LIFE ACTIVITY AFFECTED BY THE DISABILITY:

11. DIET PRESCRIPTION AND/OR ACCOMMODATION: *(PLEASE DESCRIBE IN DETAIL TO ENSURE PROPER IMPLEMENTATION)*

12. INDICATE TEXTURE:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. FOODS TO BE OMITTED AND SUBSTITUTIONS: *(PLEASE LIST SPECIFIC FOODS TO BE OMITTED AND SUGGESTED SUBSTITUTIONS. YOU MAY ATTACH A SHEET WITH ADDITIONAL INFORMATION)*

A. Foods To Be Omitted	B. Suggested Substitutions

14. ADAPTIVE EQUIPMENT:

15. SIGNATURE OF PREPARER*	16. PRINTED NAME	17. TELEPHONE NUMBER	18. DATE

19. SIGNATURE OF MEDICAL AUTHORITY*	20. PRINTED NAME	21. TELEPHONE NUMBER	22. DATE

*** Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or registered nurse must sign the form.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

In accordance with Federal law and U.S. Department of Agriculture policy, this agency is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of

Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410, or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

INSTRUCTIONS

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, community center, etc.)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.)
10. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability. For example: "Allergy to peanuts causes a life-threatening reaction."
11. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
12. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
13. A. **Foods to Be Omitted:** List specific foods that must be omitted. For example, the "exclude fluid milk."
    B. **Suggested Substitutions:** List specific foods to include in the diet. For example, "calcium fortified juice."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. (Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
15. **Signature of Preparer:** Signature of person completing form.
16. **Printed Name:** Print name of person completing form.
17. **Telephone Number:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name:** Print name of medical authority.
21. **Telephone Number:** Telephone number of medical authority.
22. **Date:** Date medical authority signed form.

DEFINITIONS*:
"A Person with a Disability" is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

"Physical or mental impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genitourinary; hemic and

lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Major life activities" are functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a record of such an impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

(*Citations from Section 504 of the Rehabilitation Act of 1973)

OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

Oakland Unified School District
Health Services Department

SEIZURE ACTION PLAN

Effective Date: _____

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name: _____ DOB: _____ Age: _____
Parent/Guardian Name: _____ Phone: _____ Cell: _____
Treating Physician: _____ Office: _____ Fax: _____
Significant Medical History: _____

SEIZURE INFORMATION: Age of child when seizures started? _____

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs: _____
Student's reaction to seizure after a seizure is over: _____
How do other illnesses affect child's seizures? _____

Daily Seizure Medication	*Dosage & Time*	*Common Side Effects & Special Instructions*

BASIC FIRST AID: CARE & COMFORT:
In addition to Basic Seizure First Aid, what other procedures should be done when child has a seizure?

Does student need to leave the classroom after a seizure? **YES** **NO**
Should an extra change of clothes be kept at school? **YES** **NO**
Does child have a VNS? **YES** **NO**
If yes, please complete the VNS authorization form.

Basic Seizure First Aid:
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

EMERGENCY RESPONSE:
A "seizure emergency" for this student is:

_____

Seizure Emergency Protocol: *(Check all that apply and clarify below)*
- ☐ Follow Seizure Emergency Guidelines
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Other _____
- ☐ Administer **EMERGENCY/RESCUE MEDICATION** as indicated below:

(Name, amount, route, frequency)

_____

Seizure Emergency Guidelines
A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*
Recommendations for physical activity: ☐ unrestricted ☐ restricted (explain) ☐ supervision (explain)

_____

Does the student need any special activity adaptations/protective equipment (e.g., helmet) at school? **YES (explain)** **NO**

Physician Name/Signature: _____ **Date:** _____
Parent or Guardian Name/Signature: _____ **Date:** _____
Reviewed by School Nurse: _____ **Date:** _____

If you have additional questions,contact HealthServices@ousd.org |www.ousd.org

Revised: July 2016

OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

Oakland Unified School District
Health Services Department

School_____ **Date** _____

MEDICAL MANAGEMENT PLAN / HEALTHCARE PROVIDER'S REPORT

(To be completed by your child's doctor, nurse practitioner or other healthcare provider)

SCHOOL ACTION PLAN FOR STUDENT WITH SPECIAL HEALTH NEEDS OR CHRONIC HEALTH CONDITIONS

Student's Name _____ **Birth date** _____

Diagnosis_____

Significant Findings: _____

_____

Does this condition impact a major life activity? ☐ **Yes** ☐ **No**
If yes, please state the major activity impacted: _____

Medications and/or treatment ordered: _____

The following are possible signs of an impending crisis:

_____

_____

Steps to be taken:
1)_____
2) _____
3) _____
4) _____

Signs that indicate the need for immediate medical care: _____

_____

_____

Recommendations for physical activity: ☐**unrestricted** ☐ **restricted** (explain) ☐**supervision** (explain)

_____

_____

Medication: Is the student required to take medication during school hours? ☐ **No** ☐ **Yes. If so, please fill out the attached medication form. Thank you.**

_____ _____ _____
Healthcare Provider's Signature **Telephone** **Fax**

_____ _____ _____
Healthcare Provider's Name/Stamp **Address/City** **Date**

If you have additional questions contact Health Services at healthservices@ousd.org
Revised: March 2017