** Catalina Camp Medication Authorization Form Directions**

6th Grade Parents/Guardians

For Students Needing ANY Medication

In order to administer **ANY** Medication to your student, **Prescription (Rx) and/or Over-the-Counter (OTC)**—Thurston Middle School requires that you deliver ANY medication and the completed HEALTH CARE PROVIDER REQUEST for MEDICATION form to the Thurston Health Office—

If ANY Medication Administrations are Needed:

1. Please print a HEALTH CARE PROVIDER REQUEST for MEDICATION form
2. Fill out and sign the Parent section
3. Deliver form to student's Physician to complete bottom section
4. Return a completed form for each Medication needed to Thurston

Examples

Rx:

- **EPI-Pens, Inhalers, Diabetes Supplies, AM & PM Medications**
- **Any Other "Must Have" Prescriptions**

OTC:

- **Advil, Tylenol, or Generic**
- **Claritin, Zyrtec, Benadryl, or Generic, etc.**
- **Dramamine, Bonine or Generic, etc.**
- **Any "Must Have" Over the Counter**

SMALL Original Product Containers Please

Return Absolutely No later than Friday, September 6th 2019.

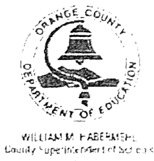
The Thurston Health Clerks must be able to log each student's medication, dietary and health information before departure.

All Medication **Must** be in its original prescription (Rx) and/or smallest (OTC) container along with the HEALTH CARE PROVIDER REQUEST for MEDICATION form filled out completely by your child's physician and you. If your child is taking more than one (1) medication you will need a form for **each additional (Rx) or (OTC).**

These medications must be clearly labeled in the original container with Student's name in a "Ziploc type bag. "

Thank you,

Elizabeth Phillips & Heidi Winegard
Thurston Health Clerks
(949)497-7785 x 2006



Orange County Department of Education
Instructional Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: ____________________ Birthdate: ____________
School/District: ____________ Teachers Name: ____________ Grade/Track: ________

Parent

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent/guardian. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: ____________________ Date: ____________

Telephone: (Work) ____________________ (Home) ____________

Physician

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

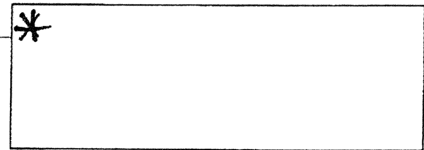
Reason for Medication: ____________________

Medication: ____________ Dose: ________ Route: ______ Time: ________

If PRN: Amount of time between doses ________ Maximum number of doses ________ per day.

Possible medication reactions: ____________________

Instructions for emergency care ____________________



Authorized Health Care Provider Signature: ____________________

Telephone ____________________

Date of Request: ____________________

Date to Discontinue Medication: ____________________

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials ________

SCHOOL USE:
Reviewed by: ____________________ Date: ____________

This request is valid for a maximum of one year.

Revised: 06/26/13