REQUEST FOR SELF-ADMINISTRATION OF MEDICATION AT SAN JOAQUIN OUTDOOR SCHOOL

(THIS FORM IS ONLY FOR AUTO-INJECTABLE EPINEPHRINE, INHALED ASTHMA MEDICATION, AND DIABETIC MEDICATIONS!)

Student: _____ Birth date: ____/____/____ Male ____ Female ____

School: _____ Teacher: _____ Grade: _____

TO BE COMPLETED BY PHYSICIAN

Medication 1	**Medication 2**
Health condition: _____	Health condition: _____
Medication name:_____	Medication name:_____
Dose (# mg, ml, puffs, etc.):_____	Dose (# mg, ml, puffs, etc.):_____
Frequency:_____	Frequency:_____
Method of Administration:_____	Method of Administration:_____
Duration(s):_____	Duration(s):_____
PRN (prescribed as needed): symptoms_____	PRN (prescribed as needed): symptoms_____
_____	_____
____For episodic/emergency events only	____For episodic/emergency events only
Special instructions:_____	Special instructions:_____
_____	_____
Restrictions and/or possible side effects	Restrictions and/or possible side effects
____none anticipated	____none anticipated
_____yes – please describe:_____	_____yes – please describe:_____
_____	_____
Special storage requirements: _____refrigerate _____none	Special storage requirements: _____refrigerate _____none
This student is both capable and responsible for self-administering auto-injectable epinephrine, inhaled asthma medication, or Diabetic medications.	This student is both capable and responsible for self-administering auto-injectable epinephrine, inhaled asthma medication, or Diabetic medications.
_____Yes-supervised	_____Yes-supervised
_____Yes-unsupervised	_____Yes-unsupervised
_____No	_____No
This student may carry medication: ____Yes ____No	This student may carry medication: ____Yes ____No

Physician's signature: _____ **Date:** _____

Phone # ( ) _____ Address: _____

I, _____, certify that the forgoing is true and correct.

Physician's Name (print)

fp (6/2012) OE 8.9f

************SEE REVERSE SIDE************

PARENT/GUARDIAN CONSENT FOR SELF-ADMINISTRATION OF MEDICATION RELEASE OF MEDICAL INFORMATION & RELEASE OF LIABILITY

I hereby consent for my child, _____, to self-administer the following medication during the regular school day or when attending school related activities:

☐ Auto-injectable epinephrine ☐ Inhaled asthma medication

☐ Diabetic Medications

I also consent to disclose identifiable health information by the health care provider to the school nurse or other personnel designated by the San Joaquin County Office of Education/Outdoor Education.

I acknowledge that I have an obligation to notify the outdoor school if my child's medication, dosage, or frequency of administration or reason for administration changes during the school year.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to hold harmless, release, and covenant not to sue the San Joaquin County Office of Education, its officers, employees, and agents, for any and all liability, claim, or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self administration of medication.

Please send TWO each of medications, one for the child to carry and one for back-up.

_____ _____ _____

Signature of Parent/Guardian | Printed Name of Parent/Guardian | Date

Attention: SCHOOL NURSE: If possible, Please attach a copy of the student's "School Inhaler/EpiPen/Diabetic Procedures" from his/her school file and attached to this form, and that they have a photo attached to each of their medication. Thank you!

☐ "School Medication Procedures" form attached

☐ Student's photo attached to his/her medication (SASI photo acceptable)

Date: _____ reviewed by School Nurse Signature of Nurse:_____

Date: _____ reviewed Principal Signature of Principal:_____

************SEE REVERSE SIDE************