McCabe Union Elementary School District

701 W. McCabe Road, El Centro, CA 92243 ~ (760) 335-5200 FAX (760) 352-4398

Health Care Provider's Authorization and Parent Consent for Management of Medication/Asthma in School and During School Sponsored Activities
2023-2024 School Year

(This form is to be completed <u>ONLY</u> if your child will need to take medication during the school day.)

TO BE COMPLETED BY A PARENT/GUARDIAN*/PARA SER COMPLETADO POR EL PADRE:*

Student's Last Name *Apellido del Estudiante*	**First Name** *Nombre*	**Sex** *Sexo*	**Date of Birth** *Fecha de Nacimiento*	**Teacher** *Maestra(o)*

I request that the following medication and/or procedure be administered to my child. I understand that the school administrator will appoint a qualified designated person(s) who will assist my child in taking the medication in accordance with the instructions provided by the physician. I will bring the medication in its original prescription bottle, properly labeled. My child may not carry the medication on their person or keep it in their lockers unless requested in writing by the physician. I authorize the school district's health care provider(s) to communicate with my child's health care provider(s) regarding his/her medical condition. I understand that whenever possible the medication should be provided before or after school hours. I will notify the school immediately if the health status of my child changes, I change health care provider or the medication is changed or discontinued.

Solicito que la siguiente medicamento y procedimiento se administre a mi hijo. Entiendo que el adminstrador de la escuela designará una persona cualificada designada (s) que ayudarán a mi hijo en la toma de la medicación de acuerdo con las instrucciones proporcionadas por el médico. Voy a traer el medicamento en su envase receta original, debidamente etiquetados. Mi hijo no puede llevar consigo el medicamento en su persona o la mantenga en sus casilleros, salvo petición por escrito por el médico. Yo autorizo que el distrito escolar proveedor de cuidados de la salud (s) para comunicarse con el proveedor de mi hijo / a de atención de salud (s) respecto a su condición médica. Entiendo que siempre que sea posible la medicación debe ser proporcionada antes o después del horario escolar. Voy a notificar a la escuela inmediatamente si la situación sanitaria de los cambios a mi hijo, yo cambio los médicos, y los medicamentos se cambia o se suspende. Si mi hijo llega tarde o sale de la escuela temprano, voy a administrar el medicamento ordenado en casa.

x_____ _____ _____

Signature of Parent/Guardian*/Firma del Padre* | Date*/Fecha* | Telephone*/Telefono*

<u>AUTHORIZATION TO CARRY AND SELF-ADMINISTER ASTHMA INHALER</u>

_____ ***Parent Initials*** My child has my permission, and is capable and responsible enough, to carry and self-administer his/her asthma inhaler as authorized below. I will provide the school with an extra inhaler to keep in the health office. *Mi hijo tiene mi permiso, y es capaz y lo suficientemente responsables como para llevar consigo y administrar un inhalador para el asma según lo autorizado a continuación. Voy a proveer a la escuela con un inhalador extra para mantener en la oficina de salud.*

TO BE COMPLETED BY A CALIFORNIA LICENSED HEALTH CARE PROVIDER

E COMPLETARA POR UN CALIFORNIA LICENCIA MEDICO

	Name of Medication	Dosage	Method of Administration	Time of Day to be Taken
1.				
2.				
3.				

<u>INFORMATION REGARDING ASTHMA & ALLERGIES</u>

Asthma Severity (circle one): mild intermittent mild persistent moderate persistent severe persistent

Asthma Triggers (check each that applies to the student):

☐ Exercise ☐ Food ☐ Pollens ☐ Stress ☐ Respiratory Infections ☐ Molds ☐ Animals ☐ Other: _____

Allergy Severity (circle one): mild intermittent mild persistent moderate persistent severe persistent

Allergy Triggers (check each that applies to the student):

☐ Nuts ☐ Food ☐ Pollens ☐ Stress ☐ Respiratory Infections ☐ Molds ☐ Animals ☐ Other: _____

Level of Independence:	**<u>Asthma</u>**	**<u>Allergy</u>**
Student is capable of self-administering medications:	Yes / No	Yes / No
Student has permission to carry medication with them:	Yes / No	Yes / No
Student can reliably report asthma symptoms:	Yes / No	Yes / No

_____ _____ _____

Print Name of Health Care Provider | Signature of Health Care Provider | Date

_____ _____ _____ _____

Address | Telephone | Fax | School Year

THIS AUTHORIZATION IS VALID FOR THE CURRENT SCHOOL YEAR

Revised May 2019