PARENT MEDICATION INFORMATION CHECKLIST

Dear Parent/Guardian:

At Orange County Head Start, we prioritize your child's health and safety. Our records show that your child may be in need of medication during school hours. Medications are rarely given in school. The only exceptions involve special or serious problems where it is deemed absolutely necessary to give the medication. We recognize that medical treatment is the responsibility of the parent and the family physician; therefore, we, OCHS staff, will follow written instructions as prescribed by your child's primary physician. It is also the responsibility of the parent/guardian to notify the Center Director should there be any changes in the medication orders. Medication orders must be renewed annually and when the medication regimen is changed.

The following checklist is to guide you through our medication procedure. If you have any questions or need assistance, please contact your Center Director.

Please complete the following steps:

- ☐ Pick up **Parent/Guardian and Physician Request for Medication (PPRM) and Medication Information Request Letter** from the center.
- ☐ Sign and date the top portion of the PPRM form.
- ☐ Take PPRM and Medication Information Request Letter to your child's doctor.
  - Make sure the doctor completes **all** sections of the PPRM form.
- ☐ Pick up the prescribed medication from your pharmacy and make sure it reflects your doctor's orders.
- ☐ Submit the completed PPRM form along with the new medication to the Center Director.
- ☐ Deliver the medication in its original container to the Center Director. If it is prescription medication, it must be labeled by the pharmacist, unaltered and unused.

  Note: Health Staff will review the medication and paperwork and will notify the Center Director once this process has been completed.
  - The Center Director will contact you to schedule the medication training.
- ☐ Attend medication training with the Center Director and other OCHS staff.

* **Your child will begin/resume school once the above steps have been completed.**

Thank you,

The OCHS Health Services Team

MEDICATION INFORMATION REQUEST LETTER

Dear Provider:

At Orange County Head Start, we prioritize our participants' health and safety. Our records show that your patient may be in need of medication during school hours. Medications are rarely given in school. The only exceptions involve special or serious problems where it is deemed absolutely necessary to give the medication. We recognize that medical treatment is the responsibility of the parent and the family physician; therefore, we, OCHS staff, will follow written instructions as prescribed by the child's physician on the attached form and pharmacy label.

The following information is to notify you of our Medication Policy and Procedure. **We ask that you read this document thoroughly and complete the Parent/Guardian and Physician Request for Medication form attached**.

OCHS Medication Policy Information:

1. The parent is urged with the help of the family physician to work out a schedule of giving medication outside school hours. **Note: Medical personnel are not available at school.**

2. Specific directions for the administration of the medication to be given at school must be included in a written statement from the attending physician, clearly specifying the condition for which the drug is to be given, how it is to be given, dosage, and related information and supplied in the original bottle from pharmacy (see attached form).

3. Specific instructions should be included for the emergency treatment of allergic reactions such as those from bee stings, and they should clearly state what type of reaction for which the drug is being given; i.e. localized, generalized, severe, and mild.

4. Medication orders must be renewed by the attending physician and a release signed by the parents at the beginning of each school year or upon entrance to school and when medication regimen is changed.

5. All prescription medication must have an unaltered label by the pharmacist **(medication label's instruction must match physician's instructions provided on medication request form).**

Thank you for your cooperation,

OCHS Health Staff

PARENT/GUARDIAN AND PHYSICIAN REQUEST FOR MEDICATION

Name of Student: ____ Birthdate: ______________________

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

California Education Code Section, 49423 allows the 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. 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 health staff to exchange medication-related information with the authorized health care provider. The health staff may counsel appropriate school personnel regarding the medication and its possible effects.

Back-up medication should be kept at school for emergency use. I release OCHS 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) _____________________

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication/Physical Condition: ____

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: _________________________________ Name (print clearly):_________________________

Telephone ____________________________________

Date of Request: ______________________________

Date to Discontinue Medication: ____________________

Office Stamp

AGENCY USE:

Reviewed by: ____ Date: ____________________

This request is valid for a maximum of one year. Follow-up by this date: ___________