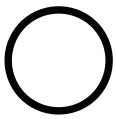

EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and rmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds. 4R510 safety guard.
5. Remove and massage the area for 10 seconds.

AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3.

PHYSICIAN INSTRUCTIONS

For SCHOOL ASSISTED MEDICATION

A. This form must be completed before any medication (prescription or over-the-counter) can be given, or taken, at school.
Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medica

Student Name: _____ Date of Birth: _____

PHYSICIAN USE ONLY
1. MEDICATION: _____ Dose: _____ Reason/Diagnosis: _____
Route ☐ Oral ☐ Nasal ☐ Topical ☐ Inhale ☐ Injection ☐ Other ___ Med Start Date: _____ Stop Date: _____
☐ If DAILY ~ Time(s) to be given:
☐

Parent Request

For Assistance with Medication at School

B. The parent or guardian must complete this page before any medication (prescription or over-the-counter) can be given, or taken, at school. Signature of parent or guardian is required. This form must be renewed each school year or with any change in medication.

Student Name: _____ Date of Birth: _____

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the control of a designated adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

A. I hereby request that the staff of my child's school assist in giving medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed

Parent or Guardian Signature: _____ Date: _____ Phone Number: _____

B. For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR SELF-CARRY: I hereby request that my student carry and self administer his/her asthma inhaler or injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying medication.* I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: _____ Date: _____ Phone Number: _____

Student Contract – Asthma Inhalers Only

I agree to keep my medication in a safe and secure place, on my person, at all times. I agree I will NEVER share medication with another student. If I am using my inhaler more than once a day, or several times a week, I will speak with the school nurse.

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

*California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Sections 48900 if that pupil uses auto-injectable epinephrine in a manner other than as prescribed.

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School/Agency Name	2. Site Name	3. Site Telephone Number

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 nurse practitioner must sign the form.**

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

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 hasa 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 offood 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, "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; musc