Helix Charter High School

Kevin Osborn, Executive Director

Dear Parent or Guardian:

RE: 2024-2025 School Year

Some students need to take medication during the school day. If this applies to your son/daughter, please have your physician complete the **"Authorization for Medication Administration"** form on the reverse side. It also needs to be signed by you. This form needs to be completed on an annual basis. It is mandatory that this form be submitted to the School Nurse prior to medication distribution to your student, *even for over-the-counter medication.*

Other students need to carry emergency or life-sustaining medication or equipment on their person **(inhaler, insulin, EpiPen, or blood glucose testing equipment only are allowed).** If this applies to your son/daughter, you and your physician also need to complete the **"Authorization for Medication Administration"** form on an annual basis.

Even if school personnel are not dispensing medication to your student, it is critical that the School Nurse ensures the proper handling and disposal of medical supplies and equipment.

If you have any questions about these procedures, please contact the School Nurse at:

Phone 619-644-1940, ext. 271
Email hurst@helixcharter.net
Fax 619-431-2409

Sincerely,

Kyja Hurst, LVN
School Nurse

Helix Charter High School

Kevin Osborn, Executive Director

Estimado Padre o Guardián:

RE: Año escolar 2024-2025

Algunos estudiantes necesitan tomar medicamentos durante el día escolar. Si esto aplica a su hijo/hija, favor de pedirle a su médico que complete el formulario de **"Autorización para la Administración de Medicamentos"** en el reverso. También debe estar firmado por usted. Este formulario debe completarse anualmente. Es obligatorio que este formulario se entregue a la Enfermera Escolar antes de la distribución de medicamentos a su estudiante, *incluso para medicamentos de venta libre*.

Otros estudiantes deben llevar consigo medicamentos o equipos de emergencia o de soporte vital **(solo se permiten inhaladores, insulina, EpiPens o equipos de prueba de glucosa de sangre)**. Si esto aplica a su hijo/hija, usted y su médico también deben completar el formulario de **"Autorización para la Administración de Medicamentos"** anualmente.

Incluso si el personal escolar no está administrando medicamentos a su estudiante, es fundamental que la Enfermera Escolar garantice el manejo y la eliminación adecuada de los suministros y equipos médicos.

Si tiene alguna pregunta sobre estos procedimientos, favor de contactar a la Enfermera Escolar al:

Teléfono 619-644-1940, ext. 271
Correo Electrónico hurst@helixcharter.net
Fax 619-431-2409

Atentamente,

Kyja Hurst, LVN
Enfermera Escolar

Helix Charter High School

Kevin Osborn, Executive Director

AUTHORIZATION FOR MEDICATION ADMINISTRATION
Education Code 49423

I, the undersigned, as legal parent/guardian of _____, _____,
(Student's Name) (Birthdate)
attending Helix Charter High School, request that the following medicine(s):_____

_____

be made available to my child at the times prescribed: _____.

I understand that only personnel authorized by the school principal will assist my child in taking the medicine(s) as directed by my physician.

I will provide the medicine(s) ***in the prescription container(s)***, which is labeled with the name of my child, the prescribing physician's name, and amount of medication prescribed.

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Prescription ***and nonprescription*** medications are not permitted to be taken at school without a written statement from the physician and a written statement from the parent indicating desire that the school assist the student as set forth in the physician's statement below.

I recognize that this is a service or accommodation that the school is not legally required to perform. I agree to save and hold the school, its officers, employees, or agents, harmless from a liability, suits or claims of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

This form valid for school

Year 2024-2025

_____ _____
Signature Date

_____
Home Address

_____ _____
Home/Cell Telephone Work Telephone

THIS PORTION TO BE COMPLETED BY A PHYSICIAN LICENSED IN THE STATE OF CALIFORNIA

1. ****Name of Medication** **Method of Administration** **Dosage** **Time of Day**

   A. _____

   B. _____

2. Discontinue "Medication A" on _____ and "Medication B" on _____
   (Date) (Date)

3. Type of assistance for administering medication (observe, measure, etc.):

   _____

4. Precautions for administration or storage of medication:

   _____

5. Do you wish to have school personnel contact you at intervals to discuss this medication? ____ Yes ____ No
   Please indicate: Person(s) _____, Intervals _____
   (Teacher, Nurse) (Weekly, Quarterly, etc.)

**** If medication is an inhaler, EpiPen, insulin, or glucose testing equipment, and may be carried on person, check here** ☐

_____ M.D./D.O. _____ _____
Printed Name of Physician Medical License Number Telephone Number

_____ _____
Signature of Physician Date

Helix Charter High School

Kevin Osborn, Executive Director

AUTORIZACIÓN PARA LA ADMINISTRACIÓN DE MEDICAMENTOS
Código de Educación 49423

Yo, _____ el firmante, coma el padre/tutor legal de _____ _____
Nombre de/ Padre/Madre *Nombre de/Alumno* *Fecha de Nacimiento*

quien asiste a **Helix Charter High School** solicito que los siguientes medicamentos: _____

_____

estén disponible para mi hijo(a) en los tiempos prescritos: _____

Yo entiendo que solo el personal autorizado por el director de la escuela ayudaré a mi hijo(a) a tomar los medicamentos según las indicaciones de mi médico.

Yo proporcionaré los medicamentos en los *envases recetados,* que están etiquetados con el nombre de mi hijo(a), el nombre del médico que los recetó *y* la cantidad de medicamentos recetados.

Si alguna de las condiciones en la Declaración del Médico cambia, el padre/tutor y el médico deben firmar un nuevo formulario.

No se permite tomar medicamentos con o sin receta en la escuela sin una declaración par escrito del médico y una declaración par escrito de los padres indicando el deseo de que el distrito ayude al estudiante como se establece en la declaración del médico a continuación.

Yo reconozco que este es un servicio o adaptación que la escuela no está legalmente obligada a realizar. Estoy de acuerdo en guardar *y* eximir de responsabilidad al distrito, sus funcionarios, empleados o agentes de responsabilidad, demandas o reclamos de cualquier naturaleza o tipo, que puedan surgir como resultado de la administración del medicamento de acuerdo con esta solicitud.

Este formulario es válido para el año escolar 2024-2025

Firma **Fecha**

Domicilio de Hogar

Numero de Telefono (casa/celular) **(trabajo)**

ESTA PARTE DEBE SER COMPLETADA POR UN MEDICO LICENCIADO EN EL ESTADO DE CALIFORNIA

THIS PORTION TO BE COMPLETED BY A PHYSICIAN LICENSED IN THE STATE OF CALIFORNIA

1. ****Name of Medication** **Method of Administration** **Dosage** **Time of Day**

   A. _____

   B. _____

2. Discontinue "Medication A" on _____ and "Medication B" on _____
   (Date) (Date)

3. Type of assistance for administering medication (observe, measure, etc.):

   _____

4. Precautions for administration or storage of medication:

   _____

5. Do you wish to have school personnel contact you at intervals to discuss this medication? _____ Yes _____ No
   Please indicate: Person(s) _____, Intervals _____
   (Teacher, Nurse) (Weekly, Quarterly, etc.)

**** If medication is an inhaler, EpiPen, insulin, or glucose testing equipment, and may be carried on person, check here** ☐

_____ M.D./D.O. _____ _____
Printed Name of Physician Medical License Number Telephone Number

_____ _____
Signature of Physician Date