LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

ROUTING
LD Superintendents
Administrators
Support Unit Administrators
Division of Special Education
Principals
APEIS
School Nurses
School Physicians
School Administrative Assistants

TITLE: Assisting Students with Prescribed Medication at School

NUMBER: BUL-3878.3

ISSUER: Smita Malhotra, MD
Medical Director
Office of the Medical Director

DATE: January 31, 2022

POLICY: This Bulletin outlines the District policies for the administration of medication at school.

MAJOR CHANGES: This is a revision of BUL-3878.2 dated July 30, 2012 of the same title. The revision includes updated information regarding bi-national health plans for asthma medication, the Medical Waste Disposal Act, nursing services checklist for medical waste, and electronic documentation in the new iSTAR.

GUIDELINES: The following guidelines apply.

I. Background

The overall goal of this Bulletin is to establish a safe and effective means whereby students are enabled to receive medications while attending school. The authority for students to receive medication at school exists in federal law and California Education Code.

California Education Code (CEC) Section 49423 provides statutory authority for providing assistance in administering medication in California schools. California Code of Regulations (CCR), Title 5, Division 1, Chapter 2, Subchapter 3, Article 4.1, provides clarification for implementing *CEC Sections 49423 and 49414.* Specifically, the regulations clarify who may administer medications to students requiring medication during the regular school day, under what conditions such administration of medication may occur, and the requirements for the delivery, administration, documentation, and disposal of medication. Information is also contained in Title 5, CCR Sections 600-602 and the Business and Professions Code (BPC). Please see the Program Advisory on Medication Administration from the California Department of Education dated 2005 for legal references.

Parents/legal guardians/educational rights holders (for purposes of this bulletin, "Parent") are notified annually of the provisions related to

administration of medications at school in the Los Angeles Unified School District (LAUSD) Parent Student Handbook. Whenever possible, it is preferable for health care providers to establish a medication schedule that will eliminate or minimize the necessity for a student to take medication during school hours. Parents are urged to ask their healthcare providers to consider such an arrangement.

II. Procedure

Students can be assisted to take medication during school hours when there is written authorization from their healthcare provider and Parent (see Attachment A). Medication supplied by Parent must be in an appropriately labeled container. Designated school personnel must receive yearly training by the school nurse.

A. Authorization from Authorized Health Care Providers

1. Required written authorizations permitting a medication to be administered in California schools shall be provided by an authorized health care provider who is licensed by the State of California to prescribe medications. Authorized health care providers include:
    a. California-licensed physicians, osteopathic physicians and surgeons
    b. California-licensed dentists, optometrists, and podiatrists
    c. California-licensed nurse practitioners and California-certified nurse midwives. (Must provide their furnishing numbers and the name, address, and telephone number of the supervising physician.)
    d. California-licensed physician assistants. (Must provide DEA number, the name, address and telephone number of the supervising physician.)
    e. California Education Code Section 49423.1 requires a school district to accept a written authorization provided by a physician or surgeon relating to a student carrying and self-administering inhaled asthma medication, from a physician or surgeon who is contracted with a prepaid bi-national health plan operating lawfully under the laws of Mexico that is licensed as a health care service plan in California. The written authorization must be provided in both English and Spanish and include the name and contact information for the physician or surgeon.

2. The written authorization for medication administration at school must contain all information on the form (see Attachment A).
    a. For all medication prescribed on an as needed basis (PRN), the healthcare provider must list the specific symptoms that necessitate the administration of medication and the allowable frequency for administration.
    b. A written authorization is not required when a Parent, or parent's designee who is not an employee of LAUSD, administers medication to their child in school.
    c. An electronic transmission copy (fax, email) is acceptable as long as the authorization is clear and legible.
    d. Telephone (verbal) authorization is NOT acceptable.

3. Parent obtains written authorization from the student's health care provider (see Attachment A). Each medication requires a separate written authorization.

4. Medication is delivered according to the licensed healthcare provider order. The school nurse/school designee cannot accept parent requests for changes/modifications to the current medication administration orders; any changes or modifications must be in writing from the licensed healthcare provider.

5. Written authorization for medication administration at school must be:
    a. Renewed annually (the authorization is valid for one calendar year from the date of the Licensed Healthcare Provider's signature).
    b. A new written authorization for medication must be submitted whenever there is a change in medication (including dose, time and/or method of administration).

6. Over-the-counter medications require written authorization from the licensed healthcare provider and parent.

B. The Parent Written Authorization

1. The parent/legal guardian/educational rights holder ("Parent") shall provide the school with a written authorization indicating their desire that the school assist the student with medication administration. (see Attachment A)

2. Written authorization from the Parent must be renewed annually or whenever there is a new written authorization from the authorized health care provider. The authorization is valid for one calendar year from the date of the Licensed Healthcare Provider's signature.

3. Parent-generated changes or modification to the medication administration directions may not be acted upon by school site personnel unless such changes are received from the authorized health care provider in writing.

4. The parent has a right to rescind their consent for administration of medication at school at any time. The Parent must submit a written authorization to discontinue the medication, and the school nurse will notify the health care provider.

C. Review of Written Authorizations

1. The school nurse will review all written authorization from authorized health care providers and the Parent to ensure that they are complete and that the medication may safely be administered in accordance with the written authorization.

2. If the school nurse is not onsite when new medication orders are received, school personnel will contact the site school nurse or the local district nursing office for assistance.

3. Each medication requires a separate written authorization.

4. The school nurse will confirm that medication containers are labeled in a manner consistent with the written authorization.

5. If the school nurse has questions or concerns regarding the written authorization, they will communicate with the authorized health care provider or pharmacist to resolve these concerns.

D. Delivery and Storage of Medication at School

1. Parent/legal guardian/educational rights holder ("Parent") or adult designee will deliver medication to the school.

2. Medication must be in a container labeled by a pharmacist licensed in the United States.

3. If multiple medications are to be administered at school, each medication must be in a separately labeled container.

4. Multiple-drug packages prepared by a pharmacist should not contain more than two medications in a single package unless special arrangements are made in consultation with District Nursing Services.

5. Over-the-counter medication that has been prescribed by an authorized health care provider must be delivered to school in the original container.

6. It is the Site Administrator's responsibility to maintain a safe environment including safe and secure storage for all medications. All medication must be stored in a locked cabinet, or a locked refrigerator, to maintain effectiveness. Refrigerators used for medication storage must be used exclusively for medication storage.

E. Persons Authorized to Administer Medication at School:

1. Persons authorized include: school nurse, licensed vocational nurse (LVN), site administrator or school designee as allowed by law, Parent or designee who is not an employee of LAUSD, contracted licensed health care professional or by the student in specific circumstances. (See Section G for self-administration of medication at school.)

2. Designated school personnel who volunteer to perform medication administration must participate in yearly training by the school nurse. The school nurse must keep documentation of supervision, review and monitoring of those trained. (See Attachment C, Attachment C-2)

3. Designated school personnel must summon a student who fails to come to the office for medication.

4. The unlicensed staff member may not administer the following: medication by injection; medication that has potential for immediate, severe, or adverse reactions; and medication that requires nurse assessment or dosage adjustment before administration, except for emergency medications as allowed by law.
    a. Emergency injectable medications such as auto-injector epinephrine, Glucagon and medication for adrenal insufficiency require a written emergency plan, medication order, protocol authorization, and training for designated school personnel by the school nurse.

(See attachment C-2)

b. Emergency medication for seizures requires a written emergency plan, medication and protocol authorizationsand training of designated school personnel by the school nurse/school physician. (See attachment C-2)
c. Designated personnel who administer life sustaining emergency seizure medication must possess current certification in cardiopulmonary resuscitation (CPR) from a recognized source of training. For administration of other emergency medications, CPR certification as above is highly recommended but not required.
d. California Educational Code Section 49414 requires school districts to provide emergency epinephrine auto-injectors to each school.
    - Refer to BUL 114500 school nurses and trained personnel to use epinephrine auto-injectors to provide emergency medical aid to persons suffering or reasonably believed to be suffering from an anaphylactic reaction. CPR is recommended but not required for non-licensed, trained personnel.
    - The Standing Order for Anaphylaxis—Epinephrine Auto-Injector is kept on file in District Nursing Services and Student Medical Services.

1. School Nurse, LVN, Parent or designee who is not an employee of LAUSD, or contracted licensed health care professional administers insulin to the student unless the student can inject themselves.

2. Designated school personnel who volunteer to monitor insulin administration by the student must participate in yearly training by the school nurse. The school nurse must keep documentation of supervision, review and monitoring of those trained.

F. Documentation of Administration of Medication in School

1. Documentation of each administration of medication is recorded in the student's electronic health record. If it is not possible to document administration of medication electronically, School Medication Record (Attachment D) may be used, so long as it is later transcribed into the electronic health record by each staff member who administered the medication.

2. Documentation will include date, time and electronic signature of the staff member administering the medication on the electronic health record, or date, time and initials and signature of the staff member administering the medication on the School Medication Record (Attachment D). The following should also be included:
    a. Documenting omitted medication; failure to administer the medication as authorized; and the date, time and means of notifying the Parent, as well as the ordering healthcare provider when applicable.
    b. A signature space on School Medication Record for the school nurse or other designated school personnel authorized to administer medication if the electronic health record is not available.
    c. Documentation of unanticipated outcomes.
    d. Maintaining the current count of controlled medication.

1. The school nurse or licensed vocational nurse (LVN) is responsible for transferring the authorized health care provider's written authorization onto the electronic or written medication log, informing all designated school personnel of changes in the medication order. When an LVN transfers this information onto the electronic or written medication log, the school nurse is responsible for reviewing the entry for accuracy and correctness. The school nurse will then enter their name in the field labeled "Reviewed by". Additional training may be provided, as needed, by the school nurse for all designated school personnel.

2. Electronic documentation of all medications administered at school occurs at the time the medication is administered. The school nurse is responsible for monitoring accurate logging of medication and adverse outcomes to medication administration in the electronic health record in Welligent. In addition, the school nurse is responsible for training other staff members on the proper procedure to document medication administration in Welligent. In the event that it is not possible to document medication administration in Welligent, written documentation on the Student Medication Record will be accepted, so long as it is later transcribed into the electronic health record by each staff member who administered the medication.

3. Medications classified as "controlled substances" (as defined by CFR [Code of Federal Regulations] Title 21, Chapter 2, Section 1300.1) must be counted and logged daily.

    a. Controlled substances are drugs that have a potential for

abuse and psychological and physical dependence. These may include opiates, stimulants, depressants, hallucinogens, and anabolic steroids such as methadone, oxycodone, morphine, hydromorphone, methylphenidae (Ritalin), demethylphenidate (Focalin), and Adderall. This is not a comprehensive list. Refer to https://ecfr.federalregister.gov/current/title-21/chapter-II/part-1300/section-1300.01

b. All controlled substances are to be counted in the presence of the Parent/designee delivering the medication. The staff member and the Parent/designee sign the Student Medication Record attesting to the count.
c. Each dose of the controlled substance that is administered is recorded and subtracted from the total count. The remaining doses are documented in the electronic health record and/or Student Medication Record.
d. Discrepancies between what has been documented as administered and the amount remaining are reported immediately upon discovery to the site administrator, local district nursing office, and school nurse. An iSTAR incident report will be initiated.

G. Self-Administration of Medication at School

1. Per section 49423.1 of the California Education Code, in order for a pupil to carry and self-administer prescription inhaled asthma medication, the school district shall obtain both a written authorization from the physician or surgeon detailing the name of the medication, method, amount and schedules by which the medication is to be taken, and confirming the student is able to self-administer inhaled asthma medication. Additionally, the District shall obtain a written authorization from the Parent of the pupil consenting to the self-administration, providing a release to the school nurse to consult with the authorized health care provider should any questions arise, and releasing the district and school personnel from civil liability if the self-administering pupil suffers an adverse reaction by taking the approved medication.

2. Students are allowed to carry and self-administer emergency or necessary medications if there is:
   a. Written authorization from the authorized health care provider. (see Attachment E)
   b. Written Parent consent. (Attachment E)

c. Documentation by the school nurse in the electronic health record of the student's capability to safely and competently perform the task.
d. Written student contract. (See Attachment F)

3. California law authorizes students of any age to carry and self-administer inhaled asthma medication and auto-injectable epinephrine.
    a. An *Asthma Action Plan* (AAP) is a written authorization that includes complete medication authorization information from the student's health care provider and Parent. It is acceptable without the need for additional District forms and is strongly recommended for all students with asthma. (See Attachment G)
    b. The school nurse will review the AAP to ensure that the plan includes all required information and release of the District from liability when a student self-administers asthma medication. The student contract will also be completed by the school nurse.

4. Pupils misusing self-administered medications are subject to specified interventions and disciplinary actions pursuant to Section 48900, et seq., of the California Education Code.

H. Errors in Administration of Medication at School

1. Any failure to properly administer medication according to the written authorization is reported immediately upon discovery to the site administrator, local district nursing office and the school nurse. The school nurse or site administrator will notify the Parent and if necessary, the authorizing health care provider at the time of the occurrence. The local district nursing administrator must also be notified.
2. All medication errors require written documentation of the error in the Incident Systems Tracking Accountability Report (iSTAR). In the new iSTAR system under "Issue Type", select "Medication/Protocol Error" If that iSTAR system is not in use at the site, then under "Issue Type" select "Medical".
3. Medication dropped on the floor and discarded is recorded on the Student Medication Record and witnessed and signed by a second adult, and
4. Controlled substances are documented in the Medication Inventory in the student's electronic health record and/or the Student Medication Record.

I. Disposal of Medications at School

1. Medications are to be returned to the Parent at the end of the school year, when discontinued, or outdated and documented on the Student Medication Record. Indicate date of return and signature of school personnel returning medication and signature of person receiving the medication. If medication is returned to the Parent by a licensed nurse, also document on the student's electronic health record.

2. If Parent has not arranged pickup within 30 days, or if medication is expired, the medication will be disposed of by the licensed nurse. The disposal should be documented on the Student Medication Record/electronic health record, and on the Medical Waste Tracking Document. Disposal is handled as medical/hazardous waste. Please follow the preparation guidelines as outlined in the Medical Waste Transport Checklist (Attachment H).

3. Medications should not be sent home with students, disposed of in school trash or flushed down the toilet.

J. Medication Administration for Field Trips and All School-Related Activities

1. The school nurse should be notified four weeks in advance of planned school-sponsored events to allow time to schedule and conduct trainings of designated school staff if medication will need to be administered. Injectable medications such as insulin require specific communication between the school nurse, Parent and local district nursing office to develop a plan for administration.

2. Designated school staff should keep medication in a closed container on their person at all times. A copy of the Student Medication Record to document time of administration and personnel administering the medication will accompany each medication..

3. It should be verified that students who self-carry medication have adequate amounts of medication and supplies with them.

K. Administration of Prescribed-as-Needed (PRN) Medication in School

1. Before a PRN medication is administered, designated school personnel validate when the medication was last given to

determine that the time interval complies with the authorized frequency of administration:

a. Check student's electronic health record or Student Medication Record for time of last dose administered.
b. Check that student has been in attendance at school for length of time of the authorized frequency.
c. Call the Parent to validate when the medication was last given at home if student has been in attendance less than the length of time of the authorized frequency.

2. Before a PRN medication is administered, the school nurse or designated school personnel validate the symptoms being experienced by the student as symptoms identified on the written authorization.

3. When recording on the student's electronic health record or Student Medication Record, include the symptoms for which the PRN medication was administered and outcome after administration.

L. Disaster Preparedness and Administration of Medication

1. The school should include procedures for access to and administration of medications to students during emergencies.

2. School nurses should consult with Parents and licensed healthcare providers regarding medications normally taken at home that may need to be available during such emergencies, such as asthma controller medication, seizure medication, diabetic medication, psychotropic medication, heart and diuretic medications, antiviral medications, or any other physician-prescribed life-saving medications. Obtain medication order(s), medication and supplies for 72 hours for disaster preparedness.

AUTHORITY: This is a policy of the Los Angeles Unified School District.

California Education Code Section 49423, 49423.1, 49423.6, 49414.5 and 49414.7.

California Code of Regulations, Title 5, Division 1 and California Code of Regulations (CCR), Title 5, Division 1, Chapter 2, Subchapter 3, Article 4.1 and sections 600- 602.

Business and Professions Code (BPC) Sections 1625, 2051, 2052, 2472, 2746.51, 2836.1, 3041, 3502.1

Medical Waste Management Act

RELATED RESOURCES:

1. Asthma Action Plan
2. California Education Code Section 48900
3. Title 21, Code of Federal Regulations (CFR) Section 1300.1
4. California Code of Regulations (CCR) Sections 600-611
5. iSTAR
6. LAUSD Parent Student Handbook
7. Program Advisory on Medication Administration from the California Department of Education dated May 2005 for Legal References
8. REF-2111 "Field Trips Handbook and Revised Procedures"
9. Glucagon, Epinephrine, and Solu-Cortef medication order forms from the DNS elibrary

ASSISTANCE:

For assistance or further information please contact Director, Student Medical Services (213) 202-7577 or Director, District Nursing Services (213) 202-7580. Please note that all attachments are available in the nursing e-library under "forms".

LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

LOS ANGELES UNIFIED SCHOOL DISTRICT

Student Health and Human Services

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by a CA Licensed Health Care Provider, or a physician or surgeon from Mexico contracted with a bi-national health plan who prescribes self-administered, inhaled asthma medication in accordance with C.E.C. Section 49423.1)

Student Name _____ _____ _____ _____
Last First Gender Birth date School

Name of Medication_____ Start date_____

Dosage prescribed_____Time schedule at school_____Route _____

How long is medication to be taken ☐ 1 Year ☐ short-term _____
Date medication to be discontinued or # of days to be given

Purpose of Medication or diagnosis_____ICD Code _____

Licensed Health Care Provider's Recommendations (Check where applicable)

☐ The medication may have adverse side effects (explain) _____

_____

☐ Special instructions and/or comments_____

_____

The student for whom this medication is prescribed is under my care.

_____ _____ _____
Print name/Title Signature Date

_____ (___)_____
Address City State Zip Code Telephone

Print name of Supervising Physician_____(NP, Midwife, PA)

Furnishing Number_____(NP/Midwife)

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS
(To be completed by parent/guardian)

I request that my child_____, be assisted in using prescribed medication at school. I assume full responsibility for supplying all medication and shall deliver it, or have it delivered, to the school by another responsible adult, and agree to the District policies and procedures listed on the reverse side. I give my permission for the exchange of medical information regarding administration of medication at school with the authorized health care provider and pharmacist.

_____ _____ _____
Date Signature of Parent/Guardian/Student 18 years Printed Name

(____)_____ (____)_____ (____)_____
Home telephone Work telephone Cellular telephone

DISTRICT PROCEDURES REGARDING MEDICATION TAKEN DURING SCHOOL HOURS

1. Prescription medications must be clearly labeled by a U.S. dispensing pharmacy and contain the following information: (consistent with prescription of authorized licensed health care provider
   - Student's full name
   - Physician's name
   - Dosage, schedule, and route
   - How long medication is to be taken? 1 year or short term: (Date medication is to be discontinued or number of days medication is to be administered.)

2. In addition to a home supply, parent/guardian may request a second labeled bottle from the pharmacy for school use.

3. Non-prescription (over the counter) medications that have been authorized by this request may be administered at school only if the medication is provided in the original container.

4. Request for Medication to be Taken During School Hours must be renewed annually.

5. Parent/Guardian will notify the school nurse or site administrator and provide a new Request for Medication to Be Taken During School Hours when there is a change in the student's medication, health status or authorized health care provider.

6. The school administrator or the administrator's designee will assume responsibility for placing the medication in a locked cabinet, storage unit or locked refrigerator.

7. The school administrator, the administrator's designee, or school nurse will assume responsibility for returning unused medication to the parent/guardian at the end of the student's school year.

8. If medication must be taken while a student is on a field trip, arrangements must be made through the school nurse.

9. All injectable medications require special arrangements.

    a. Injectable medications, such as insulin, used on a regular or as needed basis must be administered by licensed health care providers and require special arrangements.

    b. Injectable medications, which are to be given on an emergency basis, require special arrangements and training of volunteer school staff by the credentialed school nurse/physician.

10. Each medication requires a separate written authorization.

LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

Student Health and Human Services

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by a CA Licensed Health Care Provider, or a physician or surgeon from Mexico contracted with a bi-national health plan who prescribes self-administered, inhaled asthma medication in accordance with C.E.C. Section 49423.1)

Student Name _____ _____ _____ _____
Last First Sex Birth date School

Name of Medication_____ Start date_____

Dosage prescribed_____Time schedule at school _____ Route _____

How long is medication to be taken ☐ 1 Year ☐ short-term _____
Date medication to be discontinued or # of days to be given

Purpose of Medication or diagnosis_____ICD Code _____

Licensed Health Care Provider's Recommendations (Check where applicable)

☐ The medication may have adverse side effects (explain) _____

_____

☐ Special instructions and/or comments _____

_____

The student for whom this medication is prescribed is under my care.

_____ _____ _____
Print name/Title Signature Date

_____ (___)_____
Address City State Zip Code Telephone

Print name of Supervising Physician_____(NP, Midwife, PA)

Furnishing Number_____(NP/Midwife)

SOLICITUD PARA EL SUMINISTRO DE MEDICAMENTOS DURANTE EL HORARIO ESCOLAR

(Deberá ser completado por el padre de familia o tutor legal)

Solicito que mi hijo(a)_, reciba ayuda en la escuela para tomar la medicación prescripta. Asumo total responsabilidad con respecto al suministro de la medicación y entregaré la misma personalmente a la escuela o a través de otro adulto responsable. Acepto las normativas y procedimientos establecidos por el Distrito al dorso de la presente solicitud. Autorizo el intercambio de información médica vinculada con la administración de la medicación en la escuela, con el médico autorizado y con el farmacéutico.

_____ _____ _____
Fecha Firma del padre, madre, tutor, o estudiante mayor de 18 años Nombre en letra imprenta

(___)_____ (___)_____ (___)_____
Teléfono particular Teléfono de trabajo Teléfono de celula

PROCEDIMIENTOS DEL DISTRITO ACERCA DEL CONSUMO DE

MEDICAMENTOS DURANTE EL HORARIO ESCOLAR

1. Los medicamentos prescritos deben estar debidamente etiquetados por una farmacia en los Estados Unidos y deben contener la siguiente información (la cual tiene que coincidir con la que aparece en una receta expedida por un proveedor de atención médica autorizado):
    - Nombre completo del estudiante.
    - Nombre del doctor.
    - Dosis, horario y vía de consumo.
    - ¿Durante cuánto tiempo se tiene que consumir el medicamento? 1 año o a corto plazo: (Fecha en que se debe descontinuar el uso del medicamento o el número de días que se debe administrar el medicamento).

2. Aparte del medicamento para uso en casa, el padre, madre o tutor legal puede solicitar en la farmacia otro recipiente del medicamento, debidamente etiquetado, para uso en la escuela.

3. Los medicamentos no prescritos o de uso público regular cuyo uso se ha autorizado por medio de este documento pueden ser administrados en la escuela sólo si el medicamento se proporciona en el recipiente original.

4. La solicitud para administrar o tomar un medicamento durante el horario escolar se debe renovar anualmente.

5. El padre, madre o tutor legal notificará a la enfermera escolar o administrador de la escuela y proporcionará una nueva Solicitud de Medicamento para Administrarse en el Horario Escolar cuando se presente un cambio de medicamento para el estudiante, en el estado de salud del educando o del proveedor de atención médica.

6. El administrador escolar o persona asignada por el administrador asumirá la responsabilidad de colocar el medicamento en un gabinete con llave, en una unidad de almacenamiento o refrigerador con llave.

7. El administrador escolar, persona asignada por el administrador o la enfermera escolar asumirá la responsabilidad de devolver el medicamento que no se ha utilizado al padre, madre o tutor legal al terminar el año escolar del estudiante.

8. Si el medicamento se tiene que consumir durante un paseo escolar del estudiante, los arreglos necesarios se deben de llevar a cabo por conducto de la enfermera escolar.

9. Se requiere de un arreglo especial para todos los medicamentos que se deben administrar por vía de una inyección.

    c. Los medicamentos que se administran por vía de una inyección, por ejemplo, la insulina, que se usan con regularidad o en caso necesario, deben ser administrados por proveedores de atención médica autorizados y requieren de arreglos especiales.

    d. Los medicamentos que se administran por vía de una inyección, los cuales se deben administrar en casos de emergencia, requieren de arreglos especiales y la capacitación de un voluntario del personal escolar por parte de una enfermera escolar o doctor acreditado.

10. Cada medicamento requiere de una autorización escrita por separado.

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services

RENEWAL OF REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

Date: _____

Student: _____

School: _____

Dear Parent or Guardian:

Your child has been assisted in taking medication at school in the past. The *Request for Medication to Be Taken during School Hours* authorization has expired and needs to be renewed. The form must be completed by your child's California Licensed Health Care Provider, or a physician or surgeon from Mexico contracted with a bi-national health plan who prescribes self-administered, inhaled asthma medication in accordance with C.E.C. Section 49423.1. The request must be signed by you and returned to the School Nurse as soon as possible.

Medication must be brought to the office in a pharmacy-labeled container by the parent/guardian or other responsible adult.

Please notify the School Nurse any time there is a change in your child's medication, health status or authorized health care provider.

_____
Principal

_____
School Nurse

DISTRITO ESCOLAR UNIFICADO DE LOS ÁNGELES
Servicios Humanos y Salud Estudiantil

RENOVACIÓN DE LA SOLICITUD PARA ADMINISTRACIÓN DE MEDICAMENTOS DURANTE EL HORARIO ESCOLAR

Fecha: _____

Estudiante: _____

Escuela: _____

Estimado padre, madre o tutor legal:

En el pasado, a su hijo(a) se la ha ayudado a tomar un medicamento en la escuela. La autorización de la *Solicitud de Medicamento para Administrarse en el Horario Escolar* ha caducado y se tiene que renovar. El formulario debe ser completo por el proveedor de atención médica o doctor, con licencia para ejercer en California, de su hijo(a) o un doctor o cirujano de México que trabaja con un plan de salud binacional que prescriba que el medicamento su puede administrar por el propio paciente o inhalar el medicamento para asma de conformidad con el Artículo 49423.1 de C.E.C. La solicitud debe contar con su firma y debe ser entregada a la enfermera escolar a la mayor brevedad posible.

El padre, madre, tutor legal u otro adulto responsable debe traer el medicamento a la dirección de la escuela en un recipiente debidamente etiquetado por la farmacia.

Por favor notifique a la enfermera escolar acerca de cualquier cambio en el medicamento para su hijo(a), en el estado de salud del educando o del proveedor de atención médica.

_____
Director

_____
Enfermera Escolar

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services
District Nursing Services

TRAINING LOG

TOPIC_____ SCHOOL YEAR _____

SCHOOL_____ DATE _____

No.	PRINT NAME	SIGNATURE	EMPLOYEE #	JOB TITLE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Training materials used _____

School Nurse Trainer's Signature _____

School Administrator's Signature _____

Distribution: School Administrator
LD Nurse Administrator
Medication/Protocol Book (Retain for 7 years)

33.204 B Rev. 9/18

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services
District Nursing Services

STUDENT SPECIFIC TRAINING LOG

Student's Name_____ Birth Date_____

School Year_____ Type of Training_____

School_____ Date_____

No.	PRINT NAME	SIGNATURE	EMPLOYEE #	JOB TITLE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Training materials used _____

School Nurse/Physician Trainer's Signature_____

School Administrator's Signature_____

Distribution: School Administrator
LD Nurse Administrator
Medication/Protocol Book (Retain in the health record file for 7 years)
Scan and Upload in DMM Tab (Attachments)

LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

Los Angeles Unified School District
Student Health and Human Services

School Medication Record

School Year: 20__/20__					Date:	
Student's Name:	Birth Date:	Gender:	Grade:		Room:	Track:
Medication:	Schedule II ☐	Dosage:	Route:	Time Schedule:	Dose Form:	Color:

	1ST WEEK					2ND WEEK					3RD WEEK					4TH WEEK					5TH WEEK				
	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F

Los Angeles Unified School District
Student Health and Human Services

School Medication Record

School Year: 20__/20__					Date:	
Student's Name:		Birth Date:	Gender:	Grade:	Room:	Track:
Medication:	Schedule II ☐	Dosage:	Route:	Time Schedule:	Dose Form:	Color:

Special Instructions or Adverse Effects:			
Date Started:	Date Discontinued (If applicable):	Name of Teacher Notified:	Date notified:
Parent's Name:		Parent's Phones Home	Work / Cell
Health Care Provider's Name:	Address:	City: / Zip Code:	Phone:
Medication order transcribed by:	Date:	Reviewed by School Nurse:	Date:

AUTHORIZED SIGNATURES (Print, Sign & Initial)

Print Name:	Signature:	Initial:	Print Name:	Signature:	Initial:
Print Name:	Signature:	Initial:	Print Name:	Signature:	Initial:
Print Name:	Signature:	Initial:	Print Name:	Signature:	Initial:

DATE	REMARKS	SIGNATURE

Instructions:

1. Indicate time administered & initial in the appropriate box.
2. For Schedule II drugs, indicate count after each dose administration in the lower box; ie: Ritalin & Dexedrine.
3. Circle count when refill of Schedule II drugs is rec'd in the lower box; also chart # of additional doses rec'd in the comment section.

8.00	1.00
SN	SN

LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

LOS ANGELES UNIFIED SCHOOL DISTRICT

Student Health and Human Services

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Student's Last Name_____ First Name_____Gender_____Birth Date_____School_____

Name of Medication_____ Start Date _____

Dosage Prescribed_____Time/Frequency_____Route_____
(Mouth, Ear, Eye, Etc.)

How long is medication to be taken? ☐ 1 year ☐ short-term _____
Date medication to be discontinued or # of days to be given

Purpose of medication or diagnosis_____ ICD Code _____

LICENSED HEALTH CARE PROVIDER (To be completed by a CA Licensed Health Care Provider, or a physician or surgeon from Mexico contracted with a bi-national health plan who prescribes self-administered, inhaled asthma medication in accordance with C.E.C. Section 49423.1)

This student's medical condition requires immediate use of_____(medication) and the student's wellbeing is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

Please check where applicable:

☐ The medication may have adverse side effects (explain): _____ Special

☐ Instructions and/or comments: _____

The student for whom this medication is prescribed is under my care.

Print name of licensed health care provider_____ Signature_____ Date_____

_____ (___)_____
Address City State Zip Code Telephone

_____ _____
Print name of Supervising Physician (if N.P., Midwife or P.A.) Furnishing Number (if N.P. or Midwife)

PARENT/GUARDIAN

I request that my child,_____, be allowed to self-administer the medication at school. I assume full responsibility for supplying all medication and agree to the District policies and procedures listed on the reverse side. I request that the school comply with the orders of the above licensed health care provider.

I believe that my son/daughter is physically, mentally, and behaviorally capable of self-administering this medication. I hereby expressly waive and release the Los Angeles Unified School District from any and all rights or claims of any nature whatsoever I may have against the Los Angeles Unified School District, the Board of Education of the Los Angeles Unified School District, and its members, volunteers and employees, arising out of, in connection with, or resulting from the above request.

I give my permission for the exchange of medical information regarding self-administration of medication at school with the authorized health care provider and pharmacist.

_____ _____ _____
Print name of parent or guardian Signature Date

(___)_____ (___)_____ (_____)_____
Telephone Work telephone Cellular telephone

SCHOOL PERSONNEL

I have received the request of the parent/guardian and orders of the above licensed health care provider and believe that the above student is physically, mentally, and behaviorally capable of self-administering this medication at school.

_____ _____ _____
Signature of School Principal Signature Date

DISTRICT PROCEDURES REGARDING SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

1. Prescription medications must be clearly labeled by a U.S. dispensing pharmacy and contain the following information: (consistent with prescription of authorized licensed health care provider)

    - Student's full name
    - Physician's name
    - Dosage, schedule, and route.
    - How long medication is to be taken? 1 year or short-term (date medication is to be discontinued or number of days medication is to be administered.)

2. Non-prescription (over the counter) medications that have been authorized by this request, must be in the original container.

3. Requests for Self-Administration of Medication during School Hours must be renewed annually.

4. Parent/Guardian will notify the school nurse or site administrator and provide a new Request for Self-Administration of Medication During School Hours when there is a change in the student's medication, health status or authorized health care provider.

5. Injectable medications, which are to be given on an emergency basis require special arrangements and training of school staff by the credentialed school nurse.

6. A copy of this authorization should be carried with the medication

LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Student's Last Name _____ First Name _____ Sex _____ Birth date _____ School _____

Name of Medication _____ Start Date _____

Dosage Prescribed _____ Time/Frequency _____ Route _____
(Mouth, Ear, Eye, Etc.)

How long is medication to be taken? ☐ 1 year ☐ short-term _____
Date medication to be discontinued or # of days to be given

Purpose of medication or diagnosis _____ ICD Code _____

LICENSED HEALTH CARE PROVIDER (To be completed by a CA Licensed Health Care Provider, or a physician or surgeon from Mexico contracted with a bi-national health plan who prescribes self-administered, inhaled asthma medication in accordance with C.E.C. Section 49423.1)

This student's medical condition requires immediate use of _____(medication) and the student's well-being is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

Please check where applicable:

☐ The medication may have adverse side effects (explain): _____

☐ instructions and/or comments: _____

The student for whom this medication is prescribed is under my care.

Print name of licensed healthcare provider _____ Signature _____ Date _____

Address _____ City _____ State _____ Zip Code _____ ( ) Telephone _____

Print name of Supervising Physician (if N.P., Midwife or P.A.) _____ Furnishing Number (if N.P. or Midwife) _____

PADRE/MADRE/TUTOR

Solicito que a mi hijo(a),_____, se le permita tomar el medicamento en la escuela. Asumo plena responsabilidad por el suministro de la medicación y me atengo a la normativa y procedimientos establecidas por el Distrito que figuran al dorso de este documento. Solicito que la escuela cumpla con las órdenes dictadas por el médico cuyo nombre figura en este documento.

Considero que mi hijo(a) se encuentra en un estado físico, mental y de conducta que le permiten asumir la responsabilidad de tomarse el medicamento por sus propios medios. Mediante la presente expresamente eximo al Distrito Escolar Unificado de Los Ángeles de todo derecho o reclamo de cualquier índole que yo pudiera tener en contra del Distrito Escolar Unificado de Los Ángeles, de la Junta de Educación del Distrito Escolar Unificado de Los Ángeles, así como contra sus integrantes, voluntarios, o empleados, que pudiera surgir a consecuencia o en relación con la solicitud presentada.

Otorgo permiso para el intercambio de información con respecto al consumo individual de medicamentos en la escuela entre el médico autorizado y la farmacia.

Nombre del padre/madre/tutor _____ Firma _____ Fecha _____

( ) Teléfono _____ ( ) Teléfono de trabajo _____ ( ) Teléfono de cellular _____

SCHOOL PERSONNEL

I have received the request of the parent/guardian and orders of the above licensed health care provider and believe that the above student is physically, mentally, and behaviorally capable of self-administering this medication at school.

Signature of School Principal _____ Signature of School Nurse _____ Date _____

DIRECTIVAS ESTABLECIDAS POR EL DISTRITO CON RESPECTO AL CONSUMO DE MEDICAMENTOS DURANTE EL HORARIO ESCOLAR

1. Los medicamentos con receta deben estar debidamente etiquetados por una farmacia de los Estados Unidos y deben contener la siguiente información: (conforme con la receta de un médico titulado y debidamente autorizado)

    - ❖ Nombre completo del estudiante
    - ❖ Nombre del médico
    - ❖ Dosis, horarios, medio y forma de administración
    - ❖ Periodo de tiempo en que se ingerirá el medicamento: 1 año o corto período de tiempo (fecha en que el medicamento debe ser descontinuado o número de días que el medicamento debe ser administrado.)
2. Los medicamentos que no requieran receta (es decir, de venta libre al público), que hayan sido autorizados a través de la presente solicitud, podrán ser suministrados en la escuela únicamente si están en su envase original

3. Las solicitudes para el suministro de medicamentos durante el horario escolar deberán renovarse anualmente.

4. En caso de ocurrir un cambio en la medicación del estudiante, en su estado de salud, o en relación al médico autorizado, el padre de familia o tutor legal le notificará a la enfermera escolar o al administrador de la escuela y llenará una nueva solicitud para el suministro de medicamentos durante el horario escolar

5. Los medicamentos inyectables, que se suministren en casos de emergencia, requieren de preparación especial y capacitación del personal escolar a cargo de la enfermera escolar habilitada.

6. Una copia de la presente autorización debe acompañar al medicamento.

A

LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

Name of Student / Nombre del estudiante	Birth date Fecha de nacimiento	School / Escuela

STUDENT CONTRACT FOR SELF-ADMINISTRATION/SELF-CARRY OF MEDICATION DURING SCHOOL HOURS

I am requesting to give and/or carry my medication at school and I agree to do the following:

- I will tell the school nurse or _____ (trained voluntary school personnel) if there are any problems with my medication, supplies or equipment.
- I will tell the school nurse or _____ (trained voluntary school personnel) when I need help or if my symptoms do not get better after taking my medication.
- I will check in with the school nurse about my medication and how often I am using it _____.
  Frequency

I understand that any misbehavior with my medication, such as sharing medications with other students or not safely handling equipment, will mean the school administrator or school nurse can take away my self-administration privilege.

ACUERDO ESTUDIANTIL PARA LA POSESIÓN Y SUMINISTRO PROPIO DE MEDICAMENTOS DURANTE EL HORARIO ESCOLAR

Solicito autorización para llevar mi medicamento a la escuela y tomármelo, actuando de conformidad con las siguientes disposiciones:

- Le notificaré a la enfermera escolar o _____ (personal escolar capacitado) en caso de surgirme algún problema con el medicamento, la dosificación, o el equipo.
- Le notificaré a la enfermera escolar o _____ (personal escolar capacitado) si necesitara ayuda o si mis síntomas no mejoraran luego de tomar la medicación.
- Hablaré con la enfermera escolar en referencia a los medicamentos y la frecuencia con que los tomo _____.
  Frecuencia

Comprendo que cualquier clase de conducta indebida con los medicamentos, como por ejemplo convidar a otros estudiantes o el uso inapropiado de equipos, llevaría a que el administrador de la escuela o la enfermera escolar me retirara el privilegio de tomarme solo(a) los medicamentos.

Signature of Student / *Firma del estudiante*	Date / Fecha
Signature of School Nurse	Date

LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

Los Angeles Unified School District | Student Health & Human Services | District Nursing Services

Please complete with your doctor.

My Asthma Action Plan

Name: _____ Date of Birth: _____

Doctor's Name: _____ Doctor's Phone Number: _____

Emergency Contact: _____ Emergency Contact Phone: _____

My triggers are: ❑ Pollen ❑ Air pollution ❑ Mold ❑ Dust mites ❑ Smoke ❑ Strong smells ❑ Cockroaches ❑ Exercise ❑ Animals ❑ Colds ❑ Stress ❑ Not taking your asthma medicine ❑ Food _____ ❑ Other _____

My asthma level is: ❑ 1 Intermittent ❑ 2 Mild Persistent ❑ 3 Moderate Persistent ❑ 4 Severe Persistent

I feel GOOD (Green Zone)
- Breathing is good, and
- No cough, tight chest, or wheeze, and
- Can work and exercise easily

Peak Flow Numbers:
_____ to _____

❑ Take asthma long-term control medicine everyday.

Medicine:	How taken:	How much:	When:	
_____	_____	_____	_____	times a day
_____	_____	_____	_____	times a day
_____	_____	_____	_____	times a day

15-20 minutes before exercise or sports, take _____ puff of _____ using a spacer.

I DO NOT feel good (Yellow Zone)
- Cough or wheeze, or
- Tight chest, or
- Hard to breath, or
- Wake up at night, or
- Can't do all activities, or (work & exercise)

Peak Flow Numbers:
_____ to _____

TAKE _____ puffs of quick-relief medicine. If not back in the Green Zone within 20 to 30 minutes, take _____ more puffs.

Medicine:	How taken:	How much:	When:	
_____	_____	_____	every _____	hours

KEEP USING long-term control medicine.

Medicine:	How taken:	How much:	When:	
_____	_____	_____	_____	times a day
_____	_____	_____	_____	times a day

Call your doctor if quick-relief medicine does not work OR if these symptoms happen more than twice a week.

I feel AWFUL (Red Zone)
- Medicine does not help, or
- Breathing is hard or fast, or
- Can't talk or walk well, or
- Chest pain, or
- Feel scared

Peak Flow Numbers:
Under _____

Get help now! Take these quick-relief medicines until you get emergency care:

Medicine:	How taken:	How much:	When:	
_____	_____	_____	_____	times a day
_____	_____	_____	_____	times a day
_____	_____	_____	_____	times a day

Get emergency care/Call 911 if you can't walk or talk because it is too hard to breathe OR if drowsy OR if lips or fingernails are gray or blue. **DO NOT WAIT!**

Sign Here Physician signature: _____ Date: _____

Authorization and Disclaimer from Parent/Guardian: I request that the school assist my child with the above asthma medications and the asthma action plan in accordance with state laws and regulations. ❑ Yes ❑ No

My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications. ❑ Yes ❑ No

Print Parent/Guardian Name: _____ Signature: _____ Date: _____

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may carry and self-administer asthma medications: ❑ Yes ❑ No

(This authorization is for a maximum of one year from signature date.)

Print Provider Name/Credentials: _____ Signature: _____ Date: _____

Provider Phone #: _____ Provider Address: _____

Los Angeles Unified School District | Student Health & Human Services | District Nursing Services

Complete con su médico.

Mi Plan de Acción Contra el Asma

Nombre: _____ Fecha de nacimiento: _____

Nombre del médico: _____ Número de teléfono del médico: _____

Contacto para emergencias: _____ Teléfono del contacto para emergencias: _____

Mis desencadenantes son: ❑ Polen ❑ Contaminación atmosférica ❑ Moho ❑ Ácaros del polvo ❑ Humo ❑ Olores fuertes ❑ Cucarachas ❑ Ejercicio ❑ Animales ❑ Resfriados ❑ Estrés ❑ No tomar su medicamento para el asma ❑ Comida _____ ❑ Otro _____

El nivel de mi asma es: ❑ 1 Intermitente ❑ 2 Persistente ❑ 3 Moderado Persistente ❑ 4 Severo Persistente

Me siento BIEN (zona verde)

- Mi respiración es buena, y
- No tengo tos, opresión en el pecho ni sibilancia, y
- Puedo trabajar y hacer ejercicio fácil

Valores del flujo máximo:

_____ a _____

❑ Tome medicamentos de control del asma a largo plazo todos los días.

Medicamento:	Cómo se toma:	Cuánto:	Cuándo:
_____	_____	_____	_____ veces por día
_____	_____	_____	_____ veces por día
_____	_____	_____	_____ veces por día

Entre 15 y 20 minutos antes de hacer ejercicio o practicar deportes, inhale _____ dosis de _____ con un espaciador.

NO me siento bien (zona amarilla)

- Tos o sibilancia, o
- Opresión en el pecho, o
- Dificultad para respirar, o
- Me despierto por la noche, o
- No puedo hacer todas las actividades (trabajo y ejercicio)

Valores del flujo máximo:

_____ a _____

INHALE _____ dosis de medicamento de alivio rápido. Si no vuelve a la zona verde dentro de los 20 a 30 minutos siguientes, inhale _____ dosis más.

Medicamento:	Cómo se toma:	Cuánto:	Cuándo:
_____	_____	_____	cada _____ horas

SIGA USANDO _____ medicamentos de control a largo plazo.

Medicamento:	Cómo se toma:	Cuánto:	Cuándo:
_____	_____	_____	_____ veces por día
_____	_____	_____	_____ veces por día

Llame a su médico si el medicamento de alivio rápido no funciona O si estos síntomas se presentan más de dos veces por semana.

Me siento MUY MAL (zona roja)

- El medicamento no me ayuda, o
- Mi respiración es dificultosa oacelerada, o
- No puedo hablar o caminar bien, o
- Dolor en el pecho, o
- Me asusto

Valores del flujo máximo:

Menos de _____

¡Obtenga ayuda ahora! Tome estos medicamentos de alivio rápido hasta que reciba atención de emergencia:

Medicamento:	Cómo se toma:	Cuánto:	Cuándo:
_____	_____	_____	_____ veces por día
_____	_____	_____	_____ veces por día
_____	_____	_____	_____ veces por día

Obtenga atención de emergencia/Llame al 911 si no puede caminar o hablar porque le cuesta demasiado respirar O se siente somnoliento O tiene los labios o las uñas de color gris o azul. **¡NO ESPERE!**

Firme aqui Firma de médico: _____ Fecha: _____

Autorización y exención de responsabilidad del padre/tutor: Solicito que la escuela ayude a mi hijo/a con los medicamentos contra el asma indicados arriba y el plan de acción contra el asma de acuerdo con las leyes y la reglamentación estatal. ❑ Sí ❑ No

Mi hijo/a puede llevar y administrarse medicamentos contra el asma y yo acepto eximir de toda responsabilidad al distrito escolar y al personal de la escuela si mi hijo/a llegara a sufrir alguna reacción adversa por administrarse los medicamentos contra el asma. ❑ Sí ❑ No

Nombre del padre/tutor: _____ Firma: _____ Fecha: _____

Proveedor de atención medica: Mi firma concede autorización para las órdenes escritas antes mencionadas. Entiendo que todos los procedimientos se implementarán de acuerdo con las leyes y la reglamentación estatal. El alumno puede llevar y administrarse medicamentos contra el asma: ❑ Sí ❑ No (Esta autorización estará vigente durante un año como máximo desde la fecha de la firma).

Nombre del proveedor/credenciales: _____ Firma _____ Fecha: _____

Teléfono del proveedor: _____ Dirección del proveedor: _____

LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

Medical Waste Transport Preparation Checklist

Medication

1. **REMOVE** identifying information
2. **MUST** have separate bags for inhalers, pills, liquid medications (including calamine lotion). DO NOT COMBINE THEM IN THE SAME BAG.
3. **PLACE** bags in a labeled cardboard box labeled "For INCINERATION" on all sides:
   Pills (Tablets) | Insulin vials | Vaccine vials | Pills | Epipens | Liquid medications
4. **DO NOT** include canisters, spacers, epipen and pills containers in the box. Recycle them if at all possible or place them in regular trash.

Remove identifying information

Remove inhalers from canister

Remove spacers

Remove Epipen from containers

Individually wrapped pills - OK to bring as is. They do not have to be taken out of the pack

Pills (tablets, capsules)

Remove pills from their original containers. Place them in a separate bag and put the containers in the recycle bin

Liquid medications (prescription including calamine lotion) keep in original containers after removing identifying information and place them in a separate bag

Hydrogen Peroxide – dispose in drain and place containers in the recycle bin

Sharps Container

- Shall contain ONLY needles or Syringes with needles
- No more than ¾ full

DO NOT combine with other wastes, such as expired medications. DO NOT put medications in the sharps container

Medical Waste Tracking Document

- Form: https://achieve.lausd.net/nursing > Nursing E-Library > Forms > Medical Waste Tracking Document and Generator Certificate
- MUST list every medication name and their count
- MUST complete a separate one for sharps container if transporting with expired medications
- MUST carry the Medical Waste Tracking Document and the Small Quantity Medical Waste Generator when transporting the medical waste to District Nursing Services

Medical Wastes Drop-Off Locations

Local District Nursing Office
OR
District Nursing Services, CD Desk: Appointment is REQUIRED
121 North Beaudry Ave., Los Angeles, CA 90012
(213) 202-7580 | (213) 202-7575