LOS ANGELES UNIFIED SCHOOL DISTRICT
Medical Services Division

REQUEST and PRIOR AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION TO BE TAKEN DURING OVERNIGHT FIELD TRIPS

(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 medication in accordance with C.E.C. Section 49423.1)

Student Last Name_____, **Student First Name**_____

Student Gender_____ **Student Birthdate**____/____/____ **School**_____

IN BOX AT LEFT, PARENT/GUARDIAN SHOULD MARK **X** TO CONSENT TO SCHOOL ADMINISTRATION OF INDICATED OVER-THE-COUNTER MEDICATIONS or PRODUCTS ORDERED BY A LICENSED HEALTH CARE PROVIDER

All over the counter medications that have been prescribed by an authorized health care provider must be delivered to the school in the original container

X	Name of Over-the-Counter (OTC) Product	Provider Dosing Recommendation including time intervals, route and purpose of medication
	Acetaminophen / generic**,** Tylenol	
	Ibuprofen / generic, Advil, Motrin	
	Naproxen / generic**,** Aleve	
	Medicated skin care ointments, creams, washes aquaphor, calamine, aftersun aloe & vitamin E, neosporin, mupirocin, anti-itch diphenhydramine cream, hydrocortisone 1% steroid cream, hibiclens antibacterial wash, betadine	
	Antihistamine / generic**,** Benadryl	
	Throat Sprays, Cough Drops	
	Decongestant / generic, Dayquil	
	Allergy medication / generic, Claritin, Zyrtec, Alegra	
	Eye drops (non prescription) **/** Saline, Visine	
	Antacid / generic, Tums, Maalox, Pepto Bismol	

Licensed Health Care Provider: Print Name_____ Sign Name_____ Date _____

Print Name of Supervising Physician_____ Furnishing Number _____
For NP, PA, Midwife *For NP, PA, Midwife*

Address: Street_____ City_____ State_____ Zip _____

REQUEST FOR MEDICATIONS TO BE TAKEN DURING OVERNIGHT FIELD TRIPS – TO BE COMPLETED BY PARENT/GUARDIAN

I request that my child_____ be assisted in using the over-the-counter medication(s) and/or product(s) denoted by X while on an overnight field trip. I understand that I assume full responsibility for supplying the medication(s) or product(s) and shall deliver it, or have it delivered, to the school by a 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 the school with the authorized healthcare provider and pharmacist.

_____ _____ ____/____/____
Printed Name of Parent/Guardian/Student over age 18 yrs **Signature of Parent/Guardian/Student over age 18 yrs** **Date**

Home Phone_____ **Work Phone**_____ **Cell Phone** _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

Printed Name of Nurse_____ **Signature**_____ **Title**_____ **Date**___/__/___

DISTRICT PROCEDURES REGARDING MEDICATION TAKEN DURING OVERNIGHT FIELD TRIPS

A. Medication Administration for Overnight Field Trips

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.

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

B. Administration of Non-Prescription (OTC) Medication on Overnight Field Trips

1. Before an OTC medication is administered on an overnight field trip, a designated school personnel will validate when the medication was last given to determine that the interval complies with the authorized frequency of the administration.

    a. Check Student Medication Record for time of last dose administered.

2. Before an OTC medication is administered, the designated school personnel will validate the symptoms being experienced by the student as symptoms identified on the written authorization.

3. When recording on the Student Medication Record, include the symptoms for which the OTC medication was given and the outcome after administration.