Office of Mary C. Barlow
Kern County Superintendent of Schools
1300 17th Street - CITY CENTRE
Bakersfield, CA 93301-4533

KEEP STUDENT MEDICATION FORM

PARENTS & GUARDIANS:

IF YOU ARE SENDING ANY MEDICATION WITH YOUR CHILD, PLEASE READ CAREFULLY

1. Please contact Assistant Superintendent Desiree VonFlue (661-636-4629) to get "Physicians Authorization to Attend" form. Notify your child's teacher immediately to arrange a medical shadow for these serious medical conditions:

   1) Any medications requiring injections (i.e. Epipen or Glucagon) or suppositories, 2) diabetes, 3) severe bee sting reaction, 4) severe food or nut allergy, 5) mobility limitations, 6) severe asthma (i.e. requiring daily nebulizer use), 7) seizures, 8) respiratory restrictions (i.e. respiratory conditions limiting activity), 9) recent hospitalizations, or 10) other serious health conditions.

2. Do not send medications your child can easily do without for the week. Send only items which must be taken or may be needed in an emergency.

3. Medication is defined as prescription and over-the-counter medicines such as aspirin, vitamins, Tylenol®, Motrin®, cough drops, etc.

4. Each medicine must be in the original container and marked with the student's name.

5. Students cannot be given medication without a "KEEP Pupil Medication Form" completely filled out and signed by both the parent and physician for each medication.

6. All students that bring medication with them must turn it in to the KEEP staff.

7. The KEEP staff will administer the oral or topical medicine as per the physician's instructions. Note: KEEP staff will **not** conduct invasive procedures requiring advanced training (such as injections, suppositories, etc.)

8. Students will not be allowed to carry any medication with them unless it is indicated on the medication form. A student's rescue inhaler will be carried in the first aid pack by KEEP staff on every hike.

9. Up to three different medications can be specified on the reverse side of this form. Use an additional sheet for other medications to be administered. This form can be found at the KEEP website: **www.campkeep.org.**

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KEEP STUDENT MEDICATION FORM

Student: _____ Date of Attendance: _____

School: _____ Teacher: _____

MEDICATION #1

Name of Medicine _____ Dosage (tabs, tsp., puffs, etc.) _____

Strength (mg., ml., etc.) _____ Frequency (hours apart, etc.) _____

SCHEDULE OF ADMINISTRATION:

❑ Daily (indicate times below) **OR** ❑ As needed (PRN) (Under what conditions?) _____

❑ 7:30AM Breakfast ❑ 12PM Lunch ❑ 3:30PM Snack ❑ 5:30PM Dinner ❑ 8PM Bed

(DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____

Comments: _____

Physician's Signature: _____ **phone #:** _____

Parent/Guardian Signature: _____ **phone #:** _____

MEDICATION #2

Name of Medicine _____ Dosage (tabs, tsp., puffs, etc.) _____

Strength (mg., ml., etc.) _____ Frequency (hours apart, etc.) _____

SCHEDULE OF ADMINISTRATION:

❑ Daily (indicate times below) **OR** ❑ As needed (PRN) (Under what conditions?) _____

❑ 7:30AM Breakfast ❑ 12PM Lunch ❑ 3:30PM Snack ❑ 5:30PM Dinner ❑ 8PM Bed

(DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____

Comments: _____

Physician's Signature: _____ **phone #:** _____

Parent/Guardian Signature: _____ **phone #:** _____

MEDICATION #3

Name of Medicine _____ Dosage (tabs, tsp., puffs, etc.) _____

Strength (mg., ml., etc.) _____ Frequency (hours apart, etc.) _____

SCHEDULE OF ADMINISTRATION:

❑ Daily (indicate times below) **OR** ❑ As needed (PRN) (Under what conditions?) _____

❑ 7:30AM Breakfast ❑ 12PM Lunch ❑ 3:30PM Snack ❑ 5:30PM Dinner ❑ 8PM Bed

(DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____ (DOSAGE) _____

Comments: _____

Physician's Signature: _____ **phone #:** _____

Parent/Guardian Signature: _____ **phone #:** _____

SIGN FOR EACH MEDICATION. COPY THIS FORM IF NEEDED.