

Authorization for Medication

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____ Room: _____

The California Education Code relating to the giving of medications at school states:

49423, Notwithstanding the provisions of Section 49422, any student who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be **assisted** by the school nurse or other designated school personnel if the school district receives (1.) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2.) a written statement from the parent or guardian of the student indicating the desire that the school district assist the student in the matter set forth in the physician's statement. All medication must be brought to school in an **original container and appropriately labeled** by the pharmacist.

TO BE COMPLETED BY A LICENSED PHYSICIAN

A. Nature of the condition requiring medication during the regular school day: _____

B. Name of Medication	Route	Dosage	Time	Self-Administer?	Self-Carry?	D/C Date
1.				<input type="checkbox"/> No <input type="checkbox"/> Yes, supervised <input type="checkbox"/> Yes, unsupervised	<input type="checkbox"/> No <input type="checkbox"/> Yes	
2.				<input type="checkbox"/> No <input type="checkbox"/> Yes, supervised <input type="checkbox"/> Yes, unsupervised	<input type="checkbox"/> No <input type="checkbox"/> Yes	
3.				<input type="checkbox"/> No <input type="checkbox"/> Yes, supervised <input type="checkbox"/> Yes, unsupervised	<input type="checkbox"/> No <input type="checkbox"/> Yes	
4.				<input type="checkbox"/> No <input type="checkbox"/> Yes, supervised <input type="checkbox"/> Yes, unsupervised	<input type="checkbox"/> No <input type="checkbox"/> Yes	

C. Upon receipt of medication orders, the school nurse and physician shall consult as needed.

Please Note: Only a licensed school nurse may administer *non-emergency* medication injections at school under the following conditions:

- A current physician's recommendation must be on file.
- The medication and equipment for administration must be furnished by the parent or physician.
- School district personnel and prescribing physician may communicate to clarify matters related to this medication in school.
- Changes in prescribed dose and other details of medication administration in school must be received in writing.

Physician's Name (Please Print): _____ Telephone No.: _____

Signature: _____ Date: _____ License No.: _____

I agree with the above:

Parent/Guardian Name (Please Print): _____ Telephone No.: _____

Signature: _____ Date: _____

Reviewed by (Name of School Nurse): _____ Telephone No.: _____

Signature of School Nurse: _____ Date: _____

Authorization for Medication

To be completed by parent or guardian

1. Please have an **adult** deliver the medication and completed form to the school.
2. After the date from discontinuance of medication specified by the physician, changes to or continuance of these arrangements must be secured by filling out a newly dated copy of this form. All medication requests must be renewed each school year if continuation of the medication is necessary.
3. I request that the school nurse, or other person designated by the principal, administer the medication as directed by the physician on the front of this sheet. I understand that school staff has my permission to communicate with the prescribing physician on matters related to this medication.

Parent or Guardian's Signature

Date

Para llenarse por el padre, madre o tutor

1. Por favor, pida a un **adulto** que entregue el medicamento y el formulario completo a la escuela.
2. Después de la fecha especificada por el médico para discontinuar el medicamento, se deberán indicar los cambios o la continuación del procedimiento presentando una nueva copia fechada de este formulario. Todas las solicitudes de administración de medicamentos deberán renovarse cada año escolar si es necesario continuarlos.
3. Solicito que la enfermera de la escuela u otra persona designada por el director/directora, administre el medicamento según lo indica el médico en el frente de esta hoja. Entiendo que los empleados de la escuela tienen mi autorización para comunicarse con el médico que recetó el medicamento respecto a asuntos relacionados con este medicamento.

Firma del Padre/Madre o Tutor

Fecha