Wiseburn Unified School District

Parent/Guardian and Authorized Health Care Provider Request for Medication

(valid for maximum of 1 year)

Name of Child: _____ Birth Date: _____

School: _____Teacher: _____Grade: _____

Parent/guardian request for the administration of Medication, Prescription and non-Prescription

California Education Code Section 49423 allows designated non-medical school personnel to assist students who are required to take medication during the day.

I request that medication be administered to my child in accordance with my authorized health care provider written instructions. I understand that designated non-medical personnel will administer medication. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for Wiseburn Unified School District personnel to exchange medication-related information with the authorized health care provider. The district nurse may counsel school personnel regarding the medication and its possible effects.

Emergency medicine such as Epi-Pen and asthma inhalers may be carried by the student when recommended by the authorized health care provider and parent. Back up medication should be kept at school for emergency use. I release WUSD and all their employees from civil liability if my child suffers an adverse reaction as a result of self-administering the medication.

Parent/Guardian Signature: _____ Date: _____

Telephone (cell)_____(home)_____(work)_____

Authorized Health Care Provider Request for Administration of Medication

Reason for Medication: _____

Medication: _____Dose: _____Route: _____ Time: _____

If PRN: Amount of time between doses_____ Maximum # of doses per day_____

Possible medication reactions: _____

Instructions for emergency care: _____

Health Care Provider Signature: _____Telephone: _____

Date of Request: _____ Date to discontinue Medication: _____

***(4th-8th grade students only) Regarding Epi-Pens/inhalers, it is my professional opinion that this student should be permitted to carry/self-administer this emergency Epi-Pen/inhaler. This student has been instructed and demonstrates and understanding of proper usage.**

Health Care Provider Initials: _____

WUSD use

Reviewed by: _____Title: _____Date: _____