13306 Fourth Street, Hickman, Ca 95323
Ph. 209-874-1816 Fax 209-874-3721

Part 1: ORDER FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

In accordance with California Education Code section 49423, this form must be completed by an authorized California healthcare provider and be on file for any student who requires medication(s) during the regular school day.

_____	_____	_____	_____	_____
Student: Last Name	***First Name***	***Middle Initial***	***DOB: month/day/year***	***Grade/Room #***

_____	_____	_____	_____
School Name	***School Phone Number***	***School Fax Number***	***Credentialed School Nurse (if applicable)***

TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER:

(California Licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants - California Code of Regulations, Title 5, section 601(a))

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

B. **Name of Medication** **Method of Administration** **Dosage** **Amount** **Time to be given** **Frequency**

_____

_____

C. **Discontinue** medication on (date): _____

D. ***Student is authorized to carry, and is able to self-administer*** *prescription for* ***asthma*** *or* ***diabetes*** *(authorized licensed healthcare provider initials:* _____).

E. **Student is authorized to carry, and is able to self-administer** auto-injectable **epinephrine** independently (authorized licensed healthcare provider initials: _____).

_____	_____	_____
Authorized Healthcare Provider Name (print)	**Signature**	**Date**

_____	_____	_____
License Number	**Phone Number**	**Fax Number**

Parental Authorization

I authorize the credentialed school nurse or other licensed healthcare provider (RN, LVN) designated by the responsible administrator, to administer the medication as directed by the authorized health care provider. I understand that the school nurse has my permission to communicate with the prescribing licensed health care provider on matters related to this medication.

_____	_____	_____	_____
Parent/Guardian Name (print)	**Signature**	**Daytime Phone Number**	**Date**

_____	_____	_____
Reviewed by Credentialed School Nurse (print)	**Signature**	**Date**

*******SEE REVERSE SIDE FOR CONTROLLED SUBSTANCE MEDICATION AUTHORIZATION OF MEDICATION DURING THE SCHOOL DAY**

Part II: ORDER FOR DELEGATION OF ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

WHEN BEING ADMINISTERED BY AN UNLICENSED VOLUNTEER SCHOOL EMPLOYEE: The prescribing California authorized licensed healthcare provider is delegating the administration of the medication ordered above to the identified unlicensed volunteer school employee, who has agreed to administer the medication. ***The licensed health care provider delegating to a designated, trained unlicensed volunteer school employee will complete the delegation authorization section below.***

I voluntarily agree to administer the medication as directed by the delegating authorized healthcare provider. I understand that I may communicate with the authorized delegating healthcare provider on matters related to the medication. My signature below affirms that I have successfully completed training to administer the medication. I understand that I may revoke my agreement to administer the medication at any time, for any reason, and will not be penalized by my employer for such revocation.

Volunteer School Employee Name (print)	Signature	Daytime Phone Number	Date
Lisa Speegle		209-874-1816 Ext 105	
Susan Hinkelman		209-874-1816 Ext 102	
Candetta Holdren		209-874-1816	
Paul Gardner		209-874-1816	
Connie Nichols		209-874-1816 Ext 163	

Delegating Healthcare Provider Name (print)	Signature	Date

I authorize the ***unlicensed volunteer school employee*** identified in this section to administer the medication as directed by the delegating healthcare provider. I understand that the unlicensed volunteer school employee has my permission to communicate with the delegating healthcare provider on matters related to this medication.

Parent/Guardian Name (print)	Signature	Daytime Phone Number	Date

Additional Requirements

1. ***Medication WILL NOT be given until this form is completed and on file in the school health office.***
2. A parent/guardian must bring the medication to the school and pick up any outdated, unused or for home use medication.
3. All medication must be in a container labeled by a pharmacist or prescribing physician
4. A current medication form must be on file. A new form for each medication must be completed and on file for each school year.
5. Parents/Guardians must provide all materials or necessary equipment for medication administration.
6. A copy of this Medication Order must be provided by the physician to the school nurse, school administrator and unlicensed volunteer.
7. Changes in prescribed dose and other details of medication administration must be provided to the school nurse, school administrator and unlicensed volunteer, in writing, by the delegating physician.
8. All medication not picked up by a parent/guardian on the last day of school will be discarded in accordance with district policy.