PALO ALTO
UNIFIED SCHOOL DISTRICT

Medication Authorization

School Hours/Field Trips/Disasters (24-72 Hours)

School _____ School Year _____ Fax _____

Student Name _____ Grade _____ DOB _____

List All Allergies: _____ Asthma: ☐ Yes ☐ No

*This form **must be renewed each school year**, **and** if there are any changes in treatment or medication during the school year.*
Medications include prescription, over-the-counter, and herbal remedies.

Physician Authorization -- Complete information below in full. Form will be returned if not completed in full.

MEDICATION # 1

Medication Name: _____ Strength: _____ Required Dose: _____

☐ Pill ☐ Liquid ☐ Injection ☐ Topical ☐ Inhaler ☐ Nebulizer ☐ Drops ☐ Nasal Spray

Route/Location of Administration: _____ Reason for giving medication: _____

Time(s) to be given at school: _____AM/PM ☐ Daily ☐ PRN If PRN, frequency: _____

If PRN, for what symptoms: _____ Relevant side effects: _____

Medication shall be administered from: _____ to _____ or ☐ Remainder of school year

Additional Instructions: _____

_____ (Physician Initial) Student may carry and self-administer the above medication without supervision. **Only inhaled asthma medication, epinephrine delivery systems, or diabetes management supplies are allowed to be carried and self-administered.**

MEDICATION # 2 (If Needed)

Medication Name: _____ Strength: _____ Required Dose: _____

☐ Pill ☐ Liquid ☐ Injection ☐ Topical ☐ Inhaler ☐ Nebulizer ☐ Drops ☐ Nasal Spray

Route/Location of Administration: _____ Reason for giving medication: _____

Time(s) to be given at school: _____AM/PM ☐ Daily ☐ PRN If PRN, frequency: _____

If PRN, for what symptoms: _____ Relevant side effects: _____

Medication shall be administered from: _____ to _____ or ☐ Remainder of school year

Additional Instructions: _____

_____ (Physician Initial) Student may carry and self-administer the above medication without supervision. **Only inhaled asthma medication, epinephrine delivery systems, or diabetes management supplies are allowed to be carried and self-administered.**

My signature below provides authorization for the above orders. All procedures will be implemented in accordance with states laws and regulations. Specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse.

Physician Printed Name _____ Physician Signature _____ Date _____

Phone _____ Fax _____ Clinic Stamp

Continue onto Page 2 for Parent/Guardian Consent. Both Physician Authorization and Parent/Guardian Consent must be completed before medication administration can begin at school.

Health Services
25 Churchill Avenue
Palo Alto, CA 94306
Tel. 650-833-4240 | Fax 650-833-4226

Updated 3/14/2025

PALO ALTO
UNIFIED SCHOOL DISTRICT

Medication Authorization

School Hours/Field Trips/Disasters (24-72 Hours)

Parent/Guardian Consent

I request that my child be allowed to take medication at school according to instruction from the above health care provider. I authorize school personnel to assist with this medication for my child as ordered from the above health care provider. I understand trained, non-medical personnel may assist with or administer medication (Ed Code 49423 and 49480).

I give consent to communication and exchange of information between PAUSD, the health care provider listed above, and the pharmacy listed on the prescription medication above regarding the health care provider's written statement or any other questions about the medication or medication administration.

I understand and agree to the following responsibilities regarding medication administration:

1. This form must be renewed whenever student's prescription changes and **at the beginning of each school year**. Forms for the next school year must be signed after the current school year has ended.
2. Prescription medication must be in a container labeled by the pharmacist or health care provider and will not be expired.
3. Non-prescription medication must be in the original container with the label intact and will not be expired.
4. An adult must bring the medication to the school health office and pick up any outdated or unused medication.
5. Pill splitting must be done by parent/guardian prior to providing medication to school officials.
6. Parent/Guardian provide all materials or necessary equipment (e.g. measuring spoon) for medication administration.
7. **Students may only carry and self-administer an epinephrine delivery systems, inhaled asthma medication, or diabetes management supplies**. Exceptions to this rule will be made on a case by case basis in consultation with the district nurse and student's physician. In order to carry and self-administer, there must be written authorization by student, parent, **and** health care provider.
8. Parent/Guardian will notify the school and provide a new written consent for any changes to the above authorization.
9. Any modifications or changes to the above authorizations may only be made after written notification is received from the health care provider.
10. I understand that 911 will be called in the event emergency medication is given. Emergency medication includes, but is not limited to, epinephrine delivery systems, glucagon, and emergency anti-seizure medications.

_____ _____ _____

Parent Signature | Phone | Date

Complete the below section if the physician indicated the student is cleared to carry and self administer inhaled asthma medication, epinephrine delivery systems or diabetes management supplies on Page 1.

Parent/Guardian Consent

I give my permission for my child to carry and self-administer the above emergency or medically necessary medication as directed by the HCP, which I have also signed. I agree that my child has been trained and is competent to carry and self-administer this medication. I release the school district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication. I understand this permission to carry and self-administer medication may be revoked by the school district if my child does not follow Universal Precautions, if my child is observed misusing the medication or medication supplies, or if having the student carry/administer this medication on campus creates an unsafe situation for students, staff or visitors to the school campus.

_____ _____

Parent Signature | Date

Student Consent

I, _____, will be responsible for carrying, administering, and keeping safe at all times, my medication.

I agree to self-administer my medication and/or manage medical equipment exactly as ordered by my health care provider. I understand that prescription medication must be in a container labeled by the pharmacist or health care provider. I understand that non-prescription medication must be in the original container with label intact. I understand that this medication/equipment is for my personal use only and must be kept in my possession. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing. I understand that I am responsible for maintaining supplies of my medication and to notify the school office if I run out of medication or supplies.

_____ _____

Student Signature | Date

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