FREMONT UNION HIGH SCHOOL DISTRICT
Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult School

AUTHORIZATION FOR MEDICATION FORM

Student's Name: ______________________________ Date of Birth:____________ Student ID: __________

School Year: _____ /_____ School Site: ______________________________

California Education Code Section 49423, notwithstanding the provisions of Section 49422 states: Any student who is required to take, during regular school hours, medication prescribed for him/her by a physician, may be assisted by the school nurse or 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, including over-the-counter medications, must be provided by parent or guardian to the school in an original container AND appropriately labeled by the pharmacist.**

TO BE COMPLETED BY PHYSICIAN

The above named student is currently under my care and receiving medication(s) for the following condition(s):

Diagnosis(es): ______________________________ ICD-10 code(s): ____________________

Medication	Controlled Substance	Taken @ home only	Dose (mg, ml, #puffs)	Rte	Time taken	Self-Administer	Self-Carry	D/C Date
Name: Symptom to treat:	❑ No ❑ Yes	❑ No ❑ Yes			❑ AM Time(s): ❑ PM Time(s):	❑ No ❑ Yes, Supervised ❑ Yes, Unsupervised	❑ No ❑ Yes	
Name: Symptom to treat:	❑ No ❑ Yes	❑ No ❑ Yes			❑ AM Time(s): ❑ PM Time(s):	❑ No ❑ Yes, Supervised ❑ Yes, Unsupervised	❑ No ❑ Yes	
Name: Symptom to treat:	❑ No ❑ Yes	❑ No ❑ Yes			❑ AM Time(s): ❑ PM Time(s):	❑ No ❑ Yes, Supervised ❑ Yes, Unsupervised	❑ No ❑ Yes	

Please Note: Renewal of this form is required for prescription changes and at the beginning of each school year.

PROVIDER STAMP HERE

______________________ Provider's Name ______________________ Provider's Signature ____________ Date

______________________ Address/City ______________________ Telephone ____________ Fax

______________________ **Parent/Guardian Name** ______________________ **Parent/Guardian Signature** ____________ **Date**

PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: _____ Date of Birth: _____ Sex: M / F

School Year: _____ /_____ School Site: _____

California Education Code Section 49423 allows the school nurse or other trained, non-medical school personnel to assist students who are required to take medication during the school day, provided that appropriate authorization is given.

"Medication" includes prescription medication, over-the-counter medication, nutritional supplements and herbal remedies. Parents are responsible for providing all medication, supplies, and equipment necessary to administer the medication. No medications, including over-the-counter medications, will be given without a prescription. The medication prescription must be current and the medication must be supplied in the **original package or original prescription bottle with the pharmacy label attached** (ask your pharmacist to divide the medication into two bottles completely labeled: one for home and one for school). The medication must be prescribed to the student to whom it will be administered, and all medication containers must include a label with the student's name, physician's name, name of the medication, and the directions for use.

Initial below:

_____ I authorize and hereby request that designated school personnel assist my child in taking the prescribed medication(s) (including prescribed over-the-counter medication, nutritional supplements, and herbal remedies) as prescribed by my child's health care provider.

_____ I agree to, and do hereby release and hold the District and its employees and contractors harmless from any and all claims, demands, causes of action, liability or loss of any type, because of or arising from acts or omissions with respect to this medication and agree to indemnify each of them with regard to any judgment or claim rendered against them arising out of this medication administration arrangement.

_____ I understand that my child may not have or take medication at school unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's health care provider and counsel school personnel as needed with regard to this/these medication(s).

_____ I have read and understood the above authorization and release. I will immediately notify the school if there is any change in medication my child is taking at school. I also understand that this authorization is in effect for a maximum of one school year, and the District will require a new authorization at the beginning of each school year, or if any changes in prescription occur.

_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

_____	_____	_____
Cell Telephone	Work Phone	Home phone