Mt. Diablo Unified School District

Concord, California

AUTHORIZATION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

Student Name _____ Birthdate _____ Grade ____

Parent/Guardian _____ Home Phone _____ Mobile _____

School _____ School Fax _____ Teacher _____

Education Code 49423, 49423.1 Any pupil who is required to take, during the regular school day, medication prescribed for him/her by a licensed healthcare provider, may be assisted by the school nurse or other designated school personnel or may carry and self-administer prescription auto-injectable epinephrine or inhaled asthma medication if the school district receives a written statement from the healthcare provider detailing the name of the medication, method, amount, and time schedules.

PART I—PARENT/GUARDIAN AUTHORIZATION *(to be completed by parent/guardian)*

I hereby request volunteer unlicensed school personnel assist my child with taking medication(s) as stated below according to healthcare provider. I understand all medication must be in the original appropriately labeled container. I understand I am required to pick up medication within one week after the last day of school or the medication will be disposed of. I also give consent for exchange of information between healthcare provider and Mt. Diablo Unified School District school personnel to communicate on matters related to this medication. I hereby release the school district and school personnel from civil liability if the student suffers an adverse reaction as a result of self-administering the medication.

_____ _____

Parent/Guardian Signature **Date**

PART II—HEALTHCARE PROVIDER AUTHORIZATION *(to be completed by provider)*

Name of Medication	Diagnosis / Indication	Dosage	Route	Time / Frequency

Please attach a list of potential side effects of the above prescribed medications.

I acknowledge volunteer unlicensed school personnel may assist student with the above prescribed medications.

_____ _____ _____

Healthcare Provider Signature **Date** **License #**

Please Print or Stamp →
Provider Name
Practice Name / Address
Contact Phone

PART III—OPTIONAL STUDENT SELF-CARRY / SELF-ADMINISTRATION

Student may self-carry and administer:

Student has been instructed and shows competency in use of listed medication(s).

_____

Name of Medication(s)

_____ _____

Healthcare Provider Signature **Parent/Guardian Signature**

Reviewed by _____ on _____ Copy to: ___ nurse ___ cum ___ med binder

Site Administrator Date

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