HAYWARD UNIFIED SCHOOL DISTRICT
AUTHORIZATION TO ADMINISTER PRESCRIBED AND OVER THE COUNTER MEDICATIONS

Student Name: _____ **School:** _____ **School Year** _____

GO#: _____ **DOB:** _____ **Grade:** _____ **Teacher/room:** _____

_____ _____ **(510) 582-8805**

(Nurse) **(Phone Number)** **(Fax Number)**

Any student who must take prescribed medication at school and who desires assistance of school personnel must submit a written statement of instructions from the licensed medical provider and a parental request for assistance in administering the medication. CA EC 49423

Supply of medication must be delivered to the school by a parent or parent designee in a container labeled by the Pharmacist. Label is to include student's name, licensed medical providers name, name and dosage of medication per California Education Code 49423.1 Changes in dosage or time of administration must be verified, in writing, by the physician. Permission is granted to the school nurse to communicate with the provider as needed per California Education Code 49480.

To be completed by LICENSED MEDICAL PROVIDER:

The above named student is to be given the following medications (including over the counter medication):

Medication	Dosage	Route	Time/Frequency	Indications/Duration	Possible side effects for this child

X _____ _____

(Licensed Medical Provider's Signature) **(Date)**

_____ _____

(Print Licensed Medical Provider's Name) **(Licensed Medical Provider's Phone Number)**

_____ _____

(Clinic/Organization/Agency) **(Address)**

To be completed by PARENT/GUARDIAN (ALL MUST be checked and initialed to be valid):

☐ _____ **initial** I am requesting that school personnel assist my student in the administration of the above prescribed mediation as directed above.

☐ _____ **initial** I release school personnel from liability from harm caused by the administration of the above prescribed medication.

☐ _____ **initial** I grant permission for the school staff and the physician to communicate regarding the student's medical condition and the prescribed medication.

X _____

(Parent/Guardian Signature) **(Date)** **(Print Parent/Guardian's Name)**

DISTRITO ESCOLAR UNIFICADO DE HAYWARD
AUTHORIZATION TO ADMINISTER PRESCRIBED AND OVER THE COUNTER MEDICATIONS

Nombre del Estudiante: _____ **Escuela:** _____ **Ciclo Escolar** _____

GO#: _____ **Fecha de/Nac:** _____ **Grado:** _____ **Maestro/salón:** _____

_____ _____ **(510) 582-8805**

(Enfermera) **(Número Telefónico)** **(Numero de Fax)**

Cualquier estudiante que deba tomar medicamento con receta médica en la escuela y que necesite asistencia por parte del personal escolar debe presentar una declaración por escrito de las instrucciones el Proveedores medicos con licencia y una solicitud de los padres para la asistencia en administrar el medicamento. CA EC 49423

El suministro de medicamento debe ser entregado a la escuela por un padre o persona designada por los padres en un envase etiquetado por el farmacéutico. La etiqueta debe incluir el nombre del estudiante, nombre el Proveedores medicos con licencia, nombre y dosis del medicamento, por requisito del Código de Educación de California 49423.1 Cambios de dosis o el horario de administración deben ser confirmados, por escrito, por el médico. Se le concede permiso a la enfermera de la escuela para comunicarse con el Proveedores medicos con licencia conforme sea necesario, por el Código de Educación de California 49480.

Para ser completado por el Proveedores medicos con licencia (To be completed by Licensed Medical Provider):

The above named student is to be given the following medications (including over the counter medication):

Medication	Dosage	Route	Time/Frequency	Indications/Duration	Possible side effects for this child

X _____ _____

(Licensed Medical Provider's Signature) **(Date)**

_____ _____

(Print Licensed Medical Provider's Name) **(Licensed Medical Provider's Phone Number)**

_____ _____

(Clinic/Organization/Agency) **(Address)**

Para ser completado por el PADRE/TUTOR LEGAL (TODO debe estar marcado y con iniciales para ser válido):

☐ _____ **iniciales** Solicito que el personal escolar asista a mi estudiante en administrar los medicamentos recetados, anteriormente mencionados, conforme se indica.

☐ _____ **iniciales** Libero al personal escolar de la responsabilidad de los daños causados por la administración del medicamento recetado anteriormente.

☐ _____ **iniciales** Concedo permiso al personal escolar y al médico para comunicarse sobre la condición medica del estudiante y el medicamento recetado.

X _____ _____ _____

(Firma del Padre/Tutor Legal) **(Fecha)** **(Nombre del Padre/Tutor Legal)**