MANTECA UNIFIED
SCHOOL DISTRICT
— MANTECA — LATHROP — FRENCH CAMP — WESTON RANCH —

Department of Health Services
Jessica Red, Coordinator | jred@musd.net | (209) 858-0782

2271 W. Louise Avenue
Manteca, CA 95337
(209) 825-3200
www.mantecausd.net

Medication Authorization Form Instructions

In compliance with Education Code Section 49423, no medication will be accepted or administered at school without meeting the requirements below. This Code allows students to take medications prescribed by a physician during the school day, to be assisted by designated school personnel with the medication, or to carry and self-administer ***certain*** medication when authorized in writing by the student's parent/guardian **AND** physician.

Administration of prescribed, non-prescribed, or Over the Counter (OTC) medications during school hours will need to meet the following requirements:

1. All medication kept at the school site must have a Medication Authorization Form.
2. **Form is required to have parent/guardian AND prescribing physician signatures.**
3. All prescribed medication must be in its **original prescription container** clearly marked with the student's name, the prescribing physician, medication name, route, dosage, time/frequency, and pharmacy
4. All nonprescription/OTC medication must be in its **original manufacturer's container,** unopened, and clearly marked with the student's name.
5. Medications that contain narcotics **will not** be administered at school.
6. All medications will be kept in a secure place in the school office. Any special instructions for storage or security measures of any medication should be written by the prescribing physician and delivered to the school office, so that such instructions can be followed.
7. **Parent/Guardian or adult student (18 years or older)** shall deliver the medication, and this completed Medication Authorization Form to the school office. Do not send medication to school with the student if they are under 18 years old.
8. **Parent/Guardian or adult student (18 years or older)** shall pick up remaining medication during the last week of school. The school site is not responsible for medication left in the office over summer, any medication not picked up will be discarded 10 days after the last day of school.

If continuance of medication is necessary, a new Medication Authorization Form
Must be completed annually, at the beginning of each new school year

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Medication Authorization Form

PARENT/GUARDIAN AUTHORIZATION

Student Name: _____ Birthdate: _____ Grade: _____ School: _____

Current Address: _____

I, the undersigned parent/guardian of the above-named minor student hereby authorize according to physician instructions below:

_____ Initials School nurse or designated school personnel to **assist** my child with medication administration, monitoring, and testing according to physician instructions and approval below.

_____ Initials My child may **carry and self-administer**: ☐ EpiPen ☐ Asthma inhaler ☐ Insulin and blood sugar monitoring/emergency supplies

I hereby RELEASE, DISCHARGE, and HOLD HARMLESS the Manteca Unified School District, officers, employees, agents from all liability, including injury, death, adverse reactions, or other damages which may arise from the self-administration or assisting with administration of medication according to the authorization and instructions of the undersigned parent/guardian and physician described herein.

I further authorize the school nurse or designated school personnel to consult with the prescribing physician should any questions arise with regard to the medication (California Education Code 49480). **I understand that continuous medication requires annual authorization submitted to the school's office, at the beginning of each new school year**.

_____ Print Parent/Guardian Name

_____ Parent/Guardian Signature

_____ Current Address

_____ Best Contact Number

_____ Date

PHYSICIAN AUTHORIZATION: THIS SECTION TO BE COMPLETED BY PRESCRIBING PHYSICIAN ONLY

Physical condition(s) for which medication(s) are being taken/diagnosis(es): _____

	Name of Medication	Dose	Frequency	Route	Time
1:					
2:					
3:					

IN EMERGENCY MAY RE-ADMINISTER MEDICATION (please specify details): _____

Possible reactions after administration of medication: _____

Storage and other precautions: _____

Start Date: ☐ Immediate or Other Date: _____ **Stop Date**: ☐ End of School Year or Other Date (if prior to end of school year): _____

_____ Initials I authorize my patient to **carry and self-administer:** ☐ EpiPen auto injector ☐ asthma inhaler ☐ diabetic medications/supplies **I confirm that I have instructed the student in the procedures, dosages, and time schedule by which the medication is to be taken and the student is COMPETENT in self-administering the medication**.

Print Name of Provider	Provider's NPI	Provider Stamp
Provider's Signature	Date	
Provider's Phone Number	Provider's FAX Number	

School Nurse Name: _____ School Nurse Signature: _____ Date: _____

Principal Name: _____ Principal Signature: _____ Date: _____

This document is in accordance with Education Code 49423 Sections (a), (b, 1, 2 & 3) and (c) EC 49423.1 Sections (a), (b, 1, 2 & 3) and (c) EC 49407.

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Autorización para Administrar Medicamentos Durante el Horario Escolar

De conformidad con la Sección 49423 del Código de Educación, no se aceptará ni administrará ningún medicamento en la escuela sin cumplir con los requisitos a continuación. Este Código permite a los estudiantes tomar medicamentos recetados por un médico durante el día escolar, ser asistidos por el personal escolar designado con el medicamento o llevar consigo y autoadministrarse ***ciertos*** medicamentos cuando lo autoricen por escrito los padres/tutores **Y** el médico del estudiante.

Administración de medicamentos recetados, sin receta o de venta libre (OTC) durante el horario escolar debe cumplir con los siguientes requisitos:

1. Todos los medicamentos guardados en el sitio escolar deben tener un Formulario de Autorización de Medicamentos firmado por su médico y padre/tutor.
2. **Se requiere que el formulario tenga las firmas del padre/tutor Y del médico que prescribe.**
3. Todos los medicamentos recetados, en su **envase original del fabricante**, claramente marcados con el nombre del estudiante, el médico que prescribe y el nombre del medicamento, vía, dosis, hora/frecuencia y farmacia.
4. Todos los medicamentos sin receta/OTC deben estar en el **envase original del fabricante**, sin abrir y claramente marcados con el nombre del estudiante.
5. No se administrarán en la escuela medicamentos que contengan narcóticos.
6. Todos los medicamentos se guardarán en un lugar seguro en la oficina de la escuela. Cualquier instrucción especial para el almacenamiento o medidas de seguridad de cualquier medicamento debe ser escrita por el médico que prescribe y entregada en la oficina de la escuela, para que se puedan seguir dichas instrucciones.
7. **7. El padre/tutor o estudiante adulto (18 años o mayor)** debe entregar el medicamento y este Formulario de autorización de medicamento completo a la oficina de la escuela. No enviar medicamentos a la escuela con el estudiante si es menor de 18 años.
8. **Padre/tutor o estudiante adulto (18 años o mayor)** deberá recoger el medicamento restante durante la última semana de clases. El sitio escolar no es responsable por los medicamentos que se dejan en la oficina durante el verano, cualquier medicamento que no se recoja se desechará 10 días después del último día de clases.

Si es necesaria la continuación de la medicación,
un nuevo formulario de Autorización para la administración de medicamentos durante el horario escolar
debe completarse anualmente, al comienzo de cada nuevo año escolar.

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Formulario de Autorización de Medicación

AUTHORIZACIÓN DE PADRES/TUTORES

Student Name/Nombre de Estudianta: _____ Birthdate/Fecha de Nacimiento: _____ Grade/Grado: _____

School/Escuela: _____ Current Address/Direccion Actual: _____

Yo, el padre/tutor abajo firmante del estudiante menor mencionado anteriormente, por la presente autorizo de acuerdo con las instrucciones del médico a continuación:

_____ Iniciales — A la enfermera de la escuela o personal escolar designado para **asistir** a mi hijo(a) con la administración, monitoreo y prueba de sus medicamentos de Acuerdo con las instrucciones y aprobación del medico abajo indicadas.

_____ Iniciales — Mi hijo(a) **puede llevar y auto-administrarse**: ☐ EpiPen ☐ Inhalador de asma ☐ Monitoreo de insulina y azúcar en sangre/suministros de emergencia

Por la presente LIBERO, DESCARGO, y EXENTO DE RESPONSABILIDAD al Distrito Escloar Unificado de Manteca, oficiales, empleados y agentes de toda responsabilidad, incluyendo lesiones, muerte, reacciones adversas u otros daños que puedan surgir de la auto administración o con la asistencia a la administración del medicamento de acuerdo con la autorización y las instrucciones del padre/tutor que firma y el médico la cuales se describen en el presente documento.

Ademàs, autorizo a la enfermera de la escuela o personal escolar designado a consultar con el médico que recetó si es que surgen preguntas en relación al medicamento (Código de Educaión de California 49480). **Entiendo que la medicación continua requiere autorizacón anual presentada en la oficina de la escuela, al comienzo de cada nuevo año escolar.**

_____ Name Parent/Guardian/Nombre del Padre/Guardiàn

_____ Parent Guardian Signature/Firma del Padre/Guardiàn

_____ Current Address/Dirección Actual

_____ Contact Number/Major Teléfono de Contacto

_____ Date/Fecha

PHYSICIAN AUTHORIZATION: THIS SECTION TO BE COMPLETED BY PRESCRIBING PHYSICIAN ONLY

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Print Name of Provider	Provider's NPI	Provider Stamp
Provider's Signature	Date	
Provider's Phone Number	Provider's FAX Number	

School Nurse Name: _____ School Nurse Signature: _____ Date: _____

Principal Name: _____ Principal Signature: _____ Date: _____

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