AUTHORIZATION FOR MEDICATION ADMINISTRATION

Pursuant to Education Code section 49423, students who are required to take medication prescribed by a physician, surgeon, or physician assistant during the regular school day (including over-the-counter medications such as aspirin, cold medicine, etc.) may obtain assistance from a school nurse or other designated employee if the District receives a written statement from both the student's physician, surgeon, or physician's assistant ("Provider"), and the student's parent/guardian authorizing the use of the medication and requesting assistance in its administration.

Except for certain self-administered medications ("epi-pen," "inhaler," or "insulin") authorized for personal use, students may not self-medicate or possess any over-the-counter or prescription medication while on District property. Unless otherwise governed by an Individualized Education Plan or Section 504 Plan, completion of this Authorization and compliance with its obligations by the parent/guardian and student is required to maintain the privilege afforded by section 49423. In addition, pursuant to Education Code section 49480 and this Authorization, the school nurse is authorized to contact the Provider below to have any question, issue, or safety concern addressed regarding the proper storage, handling, or administration of the medication, and the possible effects of the drug on the student's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects, omission, or overdose. District employees may also communicate the existence of this Authorization to teachers and other employees who may supervise the Student.

Student Information

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

Date of Birth: _____ **School ID:** _____

School: _____ **Grade:** _____

Parent/Guardian Authorization: I hereby authorize as follows:

_____ Designated District personnel may assist my child with medication administration, monitoring, and testing according to the Provider's instructions and approval below.

_____ My child may carry and self-administer an auto-injector epinephrine pen, an asthma inhaler, or insulin according to the Provider's instructions and approval below.

_____ The school nurse may communicate with the Provider and may communicate with District employees regarding the possible effects of the medication on my child's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects, omission of medication, or overdose.

I will provide the medications authorized by the Provider in original prescription containers, labeled with the name of the student, the name of the prescribing Provider, and the medication name, dosage, method, and time schedule for administration. If an over-the-counter

medicine, it will be provided in the original, purchased container. I will pick up any remaining medication on the last day of the school year.

Waiver of Liability:

By signing below, I hereby release the District from any and all claims against the District and its personnel if my child suffers an adverse reaction as a result of self-administering auto-injectable epinephrine.

I understand that Education Code section 49407 states: "Notwithstanding any provision of any law, no school district, officer of any school district, school principal, physician, or hospital treating any child enrolled in any school in any district shall be held liable for the reasonable treatment of a child without the consent of a parent or guardian of the child when the child is ill or injured during regular school hours, requires reasonable medical treatment, and the parent or guardian cannot be reached, unless the parent or guardian has previously filed with the school district a written objection to any medical treatment other than first aid." To the fullest extent allowed by Section 49407 and California law, I understand that I am waiving any potential claim I may have against the District, its officers, and employees regarding their assistance in compliance with this Authorization.

A new Authorization Form must be completed (1) when a medication, dosage, frequency of administration changes, or reason for administration changes; or (2) at the commencement of a new school year. I may revoke this Authorization, in writing, at any time, by providing written notice to **KiAsha Maciel** at kiasha.maciel@hjuhsd.org

Date: _____

Student Name: _____

Parent/Guardian Printed Name: _____

Signature: _____

Address: _____

Emergency Contact: _____ **Emergency Phone:** _____

Home Phone: _____ **Cell Phone:** _____

PROVIDER AUTHORIZATION
(To be completed only by a California Provider issuing the prescription(s))

Patient/Student Name: _____

DOB: _____

Name of Medication	Dosage/Method of Admin/Time of Day	Discontinue Date
#1)		
#2)		
#3)		
#4)		

Special Instructions/Storage/Administration Procedures/Precautions:

#1) _____

#2) _____

#3) _____

#4) _____

_____ I authorize designated school district personnel to assist my patient with medication administration, monitoring, and testing according with these Instructions.

_____ I authorize my patient to carry and self-administer ___ an auto-injector epinephrine pen, ___ an asthma inhaler, or ___ insulin according to instructions I have provided to my patient. I further confirm that the patient is able to self-administer ___ an auto-injector epinephrine pen, ___ an asthma inhaler, or ___ insulin according to such instructions.

_____ _____
Print Name of Provider CA Medical License Number

_____ NPI#_____
Provider's Signature

_____ ORP: _____ Yes ___ No ___
Provider's Telephone Number

_____ Date: _____
Provider's Facsimile Number