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
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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.