San Juan Unified School District
Authorization for Medication Administration

Pursuant to Education Code section 49423, students required or needing medication (prescribed or over-the-counter, including aspirin, cold medicine, etc.) during the school day may obtain assistance from a school nurse or other designated employee if the District receives a written statement from the student's physician NP or PA and parent/guardian authorizing the use of the medication and 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, a District employee is authorized to contact the Physician below to have any question, issue, or safety concern addressed regarding the proper storage, handling, or administration of the medication and to communicate the existence of this Authorization to teachers and other employees who may supervise the Student.

Student Information **School Year: _____**

Student Name: _____

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

School: _____ **Grade: _____**

Parent/Guardian Authorization: I hereby authorize:

____ Designated District personnel may assist my child with medication administration, monitoring, and testing according to the Physician'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 Physician's Instructions and approval below.

I will provide the medications authorized by the Physician in original prescription containers, labeled with the name of the student, the name of the prescribing physician, the medication name, and dosage. 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.

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 or dosage changes, or (2) at the commencement of a new school year. I may also revoke this Authorization, in writing, at any time.

Date: _____

Parent/Guardian Printed Name: _____

Signature: _____

Address: _____

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

Emergency Phone: _____ **Cell Phone: _____**

San Juan Unified
SCHOOL DISTRICT

<u>Physician Authorization</u> (To be completed only by a California physician issuing the prescription(s))

Patient/Student Name: _____ DOB: _____

Date of Last Medical Evaluation: _____

Name of Medication:	**Dosage/Method of Admin./Time of Day:**	**Discontinue:**
#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.

_____ _____
Print Name of Physician CA Medical License Number

_____ NPI#_____
Physician's Signature

_____ ORP ____Yes ____No
Physician Telephone Number

_____ Date _____
Physician Facsimile Number