



STUDENT  
PICTURE  
HERE

**Request for Medication Administration During School Hours**  
(Spanish)

Student: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Approved by School Nurse:  
 \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER CALIFORNIA CODE OF REGULATIONS TITLE 5, SECTION 601(A)**

*\*Self-Administration ONLY for Auto-Injectable Epinephrine, Inhaled Medication, and Diabetes Medication*

DX/REASON	MEDICATION	DOSE	ROUTE	TIME	SIDE EFFECTS	For as needed meds, symptoms allowing administration	To be kept in the health office	*Student may self-carry and self-administer

If indicated (checked) above, I give permission for the above student to carry and self-administer medication. I have confirmed that the student is capable of appropriate self-administration. If the student is younger than 18, the parent/guardian assumes all liability related to this student's use, timing and technique in self-administering this medication. Other medication(s) will be kept and administered accordingly.

I understand that specialized physical health care services may be performed by unlicensed/non-medical designated school personnel under the training and supervision provided by the school nurse or other health care professional.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: (Please Print) \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Clinic Stamp Here

**DEBE SER LLENADO POR UN PADRE/GUARDIÁN**

Yo pido que a mi niño se le permita tomar medicamentos durante las horas de escuela de acuerdo a las instrucciones del Doctor del niño. Yo entiendo es mi responsabilidad **traer los medicamentos en su envase original provisto por la farmacia, con el rotulo que contenga el nombre del niño, el nombre del medicamento, la dosis, y las instrucciones** (Código Educacional 49423) y de notificarle a la escuela si hay un cambio de medicamentos o si el niño ya no la necesita. Yo le doy autorización al personal de escuela de asistir con este medicamentos (Código Educacional Sección 49423 y 49480). Doy mi consentimiento para el intercambio de información entre el doctor y/o el farmacólogo y la enfermera de la escuela o su designado para asegurar la administración segura del medicamento(s) incluido(s) en la lista su doctor. **Yo entiendo esta forma debe ser puesta al día cada año y también cuando cambie la receta.** Yo entiendo que desechara los medicamentos que no se recojan una semana después del terminar el año escolar.

Firma del Padre/Guardián: \_\_\_\_\_ Fecha: \_\_\_\_\_

Números de teléfono durante el día: \_\_\_\_\_ y \_\_\_\_\_

STUDENT CONTRACT FOR CARRYING OWN MEDICATION: I \_\_\_\_\_ will be responsible for carrying, administering, and keeping safe at all times, my medication. I will use the medication in the way prescribed by my physician. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing.