



Liberty Union High School District

20 Oak Street

Brentwood, CA 94513

Phone: (925) 634-2166 Fax (925) 634-1687

Denise Rugani, Superintendent

Dear Parent/Guardian:

The California Education Code 49423 and 49423.5 have specific guidelines for all public schools regarding the administration of medication for both prescription AND over-the-counter medications. Below is a summary of the requirements:

- A medication authorization form must be completed each school year for students receiving and/or carrying medication at school and school sponsored events. This form is valid for the current school year only and must be updated whenever there are changes to the medication AND at the beginning of each school year. Please see attached form.
- All medication must be delivered to the school office by an adult parent/guardian.
- All medication must be in its original labeled container and not expired. Please label over-the-counter medication with the student's name.
- Parent/guardian is responsible for monitoring expiration dates and replacing expiring medication.
- All medication will be kept locked in the health office and managed by designated staff.
- Students may be allowed to self-carry and self-administer their medication with the approval of the physician and parent/guardian. Parent/guardian is responsible for verifying the medication matches the physician's instruction and is not expired. Permission to self-carry and self-administer can be denied if medication is shared or misused.
- Parent/guardian is responsible for providing all supplies (e.g. measuring cup/syringe, pill cutter, etc.)
- Designated school staff will look over forms and medication for correctness. Medication or authorization forms not meeting requirements will not be accepted.

Please complete the attached "Permission to Give Medication at School" form and deliver it, along with your student's medication, to the school office. Additional medication authorization forms are available at your school office and the district's nursing webpage at <https://ca01001129.schoolwires.net/Page/124>

For any questions, please contact your school site or email our district nurse at mashorec@luhsd.net.

Thank you for your understanding and cooperation,
LUHSD Health Services Department

Permission to Give Medication at School

Liberty Union High School District

California Educational Code Section 49423 and 49423.5

School Year:

This authorization is valid for the current school year only

Student's Last Name _____

First Name _____

Date of Birth _____

Grade _____

****TO BE COMPLETED BY: Authorized Healthcare Provider**

Medication Name	Dosage	Route	Time/ Frequency	Reason	Check if OK to Self- Carry & Administer

Side Effects _____

Precautions / Special Directions: _____

Student has permission to self-carry the designated medication(s) above at school and to self - administer such medication with or without supervision of school personnel. The student has been instructed in and demonstrates an understanding of proper usage.

Yes No

I understand that medication administration may be performed by an unlicensed designated school personnel under the training and supervision provided by the school nurse or other health care professional unless otherwise specified. This Authorization is valid for the current school year only.

Print Name of Authorized Healthcare Provider

Signature of Authorized Healthcare Provider

License # / Furnishing #

Date Authorized

Healthcare Provider Office Stamp

****TO BE COMPLETED BY: Parent/Guardian**

Per California Ed. Code Section 49423 I request and give permission for the school to administer the above medication to my child in accordance with our authorized healthcare provider's written instruction. I understand that medication administration may be performed by an unlicensed designated school personnel under the training and supervision provided by the school nurse or other health care professional unless otherwise specified. I understand it is my responsibility as the parent/guardian to keep the school supplied with and informed of any changes in my child's medication(s). I, or a designated adult, will bring the medication to the school in its original container or prescription bottle. I also understand it is my responsibility to monitor expiration dates of all prescription or over-the-counter medication(s) I bring to school. I authorize the school nurse to communicate with the health care provider when necessary. I understand this authorization is valid for the current school year only and that I may terminate the consent for the administration of the medication or for otherwise assisting my child in the administration of medication at any time.

Parent/Guardian Initial to Agree to Self-Carry, Self-Administer Medication(s)

As per the healthcare provider's authorization above, I request and give permission for my child to self-carry and self-administer the above medication(s) during the school day and school sponsored events. My child has been instructed in the treatment plan and demonstrates an understanding of proper usage and self-administration of the above prescribed medication(s). I indemnify and hold the District and its employees harmless from any liability resulting from injury / damages from my child carrying and self-administering the above medication(s). I understand that the privilege of carrying medication on campus may be revoked if the medication is used in a manner other than prescribed.

Print Name of Parent/Guardian _____ Phone _____

Signature of Parent/Guardian _____ Date _____