AUTHORIZATION FOR PRESCRIBED AND OVER THE COUNTER MEDICATION
TEMECULA VALLEY UNIFIED SCHOOL DISTRICT School Year: _____

SCHOOL SITE: _____ FAX# _(951)_____

Name of Student	Date of Birth	Grade	School

Education code 49423 authorizes that any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.
(Education Code 49414.7, 49423; 5 CCR 600)

- If your physician would like your child to carry either an asthma inhaler or emergency medication (auto-injectable epinephrine, i.e. EpiPen), Part III must be completed by the doctor, parent and child.
- The parent or adult representative designated by the parent must bring all prescribed medications to school in its prescription-labeled container.
- Over-the-counter medications must be brought in an unopened container.
- All medications will be maintained in the Health Office with the exception of medications designated in Part III, as prescribed by the physician.
- Parent/guardian may pick up medication at the close of the school year. Medication remaining after the last day of school will be properly discarded.

PHYSICIAN AUTHORIZATION

(ONE MEDICATION PER FORM)

I. **PRESCRIBED MEDICATION REQUIRED TO BE ADMINISTERED DURING SCHOOL HOURS** **(THIS SECTION IS TO BE COMPLETED BY PHYSICIAN)**

Name of medication(s)	Health condition for which medication is prescribed
Time(s) to be taken	Dosage
Route of administration	Precaution-possible untoward reactions
Physician NPI:	Date to Discontinue/ Special storage instructions
Name of physician (Please print)	Physician's telephone number Fax number ( )
Physician's signature	Date

II. **THIS SECTION IS TO BE COMPLETED BY PARENT/GUARDIAN** (Parts I AND II MUST BE COMPLETED)

I give permission for my child to receive the above medication at school according to the district board policy and administrative regulations, and agree to release, indemnify and hold harmless **TEMECULA VALLEY UNIFIED SCHOOL DISTRICT** its board member, officers, agents & employees from lawsuits, claims, demands, actions or expenses that may arise against them for administering medication as set forth in accordance with the provision of part I above.

- I understand that medication may be administered by the school nurse or other designated trained unlicensed school personnel. **(**Education Code 49414.7, 49423; 5 CCR 600)
- I agree to allow communication and the exchange of pertinent medical information between medical providers and the School Nurse involved with my child's medical care.
- I understand that I may terminate consent for such administration of medication at any time, in writing.

Signature of Parent/Guardian:_____Relationship:_____ Date: _____

NO MEDICATION WILL BE ADMINISTERED WITHOUT THE REQUIRED SIGNATURES

THIS FORM MUST BE RENEWED THE BEGINNING OF EACH SCHOOL YEAR OR WHEN THERE IS A CHANGE IN MEDICATION/INSTRUCTIONS
(Self-administered medication consent form is on Page 2)

AUTHORIZATION AND PROTOCOL FOR SELF-ADMINISTERED MEDICATION
TEMECULA VALLEY UNIFIED SCHOOL DISTRICT

(PAGE 1 AND 2 MUST BE COMPLETED FOR SELF-ADMINISTERED MEDICATION)

Name of Student	Date of Birth	Grade	School

In order for your child to carry a self-administered emergency medication on his/her person, the following must be understood and agreed upon by the student and parents: The student may utilize the prescribed self-administered medication as needed and directed by his/her physician. The Doctor's signature indicates the student has been instructed on the proper use of the prescribed medication. The medication must be properly labeled with the student's name**.** ***Both the Authorization for Prescribed Medication form and this Protocol*** must be signed by the parent/guardian and placed on file at the school prior to your child carrying a self-administered medication on his/her person.

Inhaler: NO DIRECT MONITORING will be conducted by the school staff. The student is responsible for self-administration of the inhaler. If the student continues having difficulty breathing, he/she should report to the health office and the parents will be notified by the appropriate school staff.
Self-administered emergency epinephrine: NO DIRECT MONITORING will be conducted by the school staff. The student is responsible for notifying school staff in the event he/she had the need to self-administer the emergency medication.

- It is the parents' responsibility to immediately notify the school if the child's health status changes, or when a change in physician and/or medication occurs. Changes in procedure must be received in writing from the physician authorizing treatment.
- The district is not responsible for any risk involved with improper handling of this medication including: overuse, improper administration, breakage, theft, loss, sharing, playing with or careless storage of the medication.
- Re-evaluation of the present protocol may be needed if the student is found to display behavior that increases the safety risks of him/her self or the students on campus.

III. PERMISSION TO CARRY AND SELF-ADMINISTER ASTHMA MEDICATION AND AUTO-INJECTABLE EPINEPHRINE (i.e. Epi-Pen)

TO BE COMPLETED BY THE PHYSICIAN: The above-named student has been instructed in the proper use of their asthma inhaler/emergency medication. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at school. He/she is capable of self-administering the medication, understands the purpose, appropriate method, and frequency of use of the asthma inhaler/emergency medication.

PHYSICIAN'S SIGNATURE:_____ DATE: _____

PRINTED/TYPED NAME OF PHYSICIAN:_____

TO BE COMPLETED BY THE PARENT/GUARDIAN: I permit my child to carry the above-listed asthma inhaler/emergency medication as ordered by his/her physician. I also specifically release the school district and all school personnel from any and all civil liability if my child suffers an adverse reaction as a result of self-administering medication during school hours.

PARENT/GUARDIAN SIGNATURE:_____ DATE: _____

TO BE COMPLETED BY THE STUDENT: I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician. I understand that using my medication in a manner other than as prescribed by my doctor can result in disciplinary action taken against me by my School/District.

STUDENT'S SIGNATURE:_____ DATE: _____

Please return the fully completed forms to your child's school health office signed by the physician, parent/guardian, and student. Medication forms must be renewed at the beginning of each school year or whenever there is a change in medication or instruction.

NO MEDICATION WILL BE ALLOWED WITHOUT THE REQUIRED SIGNATURES