



HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

AUTHORIZATION FOR ADMINISTERING MEDICATION REQUIRED DURING REGULAR SCHOOL DAY

California Education Code, Section 49423, allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school, to maintain or improve health status and to improve the potential for education and learning.

STUDENT NAME: _____ BIRTHDATE: _____ SEX: _____

SCHOOL OF ATTENDANCE: _____ GRADE: _____

DIAGNOSIS: _____

**This Section to be
Completed by Physician
Licensed in California**

Medication prescribed _____

Dose Form: _____ Dose Amount: _____ Time of Day: _____

Method of administration: _____

Check One:

Medication administered until: _____

PRESCRIPTION

Date

☐ Initial

Precautions or possible adverse side effects, if any:

☐ Change

It is necessary for this medication to be taken by the above named student during the school day as prescribed.

Physician: _____ License No.: _____

PRINT NAME

Address: _____

Phone Number: _____

Physician's Signature: _____

Date: _____

**This Section to be
Completed by Parent**

I authorize school personnel to administer the above medication to my child as ordered by our physician. I authorize designated staff to communicate with the physician regarding my child's medical condition and/or the medication prescribed.

Parent/Guardian: _____

Phone: _____ / _____ / _____
Home Cell Work

Medicine will be brought to school by the parent or guardian or other designated adult.

MEDICATION MUST BE IN AN ORIGINAL CONTAINER PROPERLY LABELED BY THE PHARMACY. NO OTHER CONTAINER WILL BE ACCEPTED. NO OVER-THE-COUNTER MEDICINES WILL BE GIVEN AT SCHOOL WITHOUT A PHYSICIAN'S ORDER.

THIS FORM MUST BE RENEWED WHENEVER THE PRESCRIPTION CHANGES AT THE BEGINNING OF EACH SCHOOL YEAR.



HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

MEDICATION AUTHORIZATION

USE OF INHALER OR EPI-PEN DURING THE SCHOOL DAY

Please PRINT clearly in Black or Blue ink

Check
Appropriate
Box:

☐ INHALER

☐ EPI-PEN

_____ has a medical condition and has been instructed in the
(Student's Name)

proper use of the _____. I, _____ and
(Inhaler or Epi-Pen) (Physician)

_____ request that _____
(Parent's Name) (Student's Name)

be permitted to carry their medication on the student's person or to keep it in her/his regular or P.E. locker, as we consider the student responsible and she/he has been instructed and understands the purpose, method, and appropriate frequency of using their medication.

We understand that the student is solely responsible for safeguarding the above noted medication.

Physician's Signature:	Date:
Parent/Guardian Signature:	Date:

THIS FORM MUST BE COMPLETED FOR THOSE STUDENTS WHO REQUEST PERMISSION TO CARRY THEIR OWN INHALER OR EPI-PEN ON CAMPUS OR KEEP IT IN THEIR LOCKER OR P.E. LOCKER.