

**OLD ADOBE UNION SCHOOL DISTRICT
AUTHORIZATION TO ADMINISTER MEDICATION FORM**

rev 3/11/24

Student's Name _____ Date of Birth _____

School _____ School year _____ Grade/Teacher _____

The California Education Code 49423 provides for any pupil who is required to take, during a regular school day, medication that is prescribed for him/her by a physician, and may be assisted by the school nurse or designated school personnel if the school district has received the following:

1. A written statement from the physician detailing the method, amount and time schedule the medication is to be taken, purpose of the medication, signed by the physician.
2. A written statement from the parent or guardian of the student indicating the desire that the school district assist the student in the matter set forth in the physician's statement, signed by the parent or guardian.

To be completed by PHYSICIAN for both prescription and over the counter medications:

Medication: _____ Reason for Medication: _____

Route: _____ Dosage: _____

Time: As needed every _____ hrs Before breakfast Before lunch Before bedtime Scheduled @ _____ o'clock
After breakfast After lunch After bedtime

Please mark if applicable:

- | | | |
|----------------------|---|---|
| A. Inhaler | <input type="checkbox"/> Keep in office | <input type="checkbox"/> Student may carry with him/her and self-administer |
| B. EpiPen | <input type="checkbox"/> Keep in office | <input type="checkbox"/> Student may carry with him/her and self-administer |
| C. Diabetic Supplies | <input type="checkbox"/> Keep in office | <input type="checkbox"/> Student may carry with him/her and self-administer |

Possible side effects: _____ Physician's **STAMP**: _____

Physician's License No: _____

Physician's **Printed** Name _____

Physician's Phone Number _____ Expiration of order: _____

Physician's Signature _____ Date: _____

Please Note:

- All medication must be provided in the original container and appropriately labeled by the pharmacist
- School Nurse and prescribing provider may communicate to clarify matters related to this medication
- **New orders are required annually and for any changes in medication regimen**

To be completed by the PARENT/GUARDIAN:

I hereby give permission for the designated school personnel to administer the above medication to my child. I authorize my child to self-administer the medication described above in A,B or C and release civil liability if student suffers an adverse reaction.

Parent Printed Name _____ Phone: _____

Parent's Signature _____ Date: _____

FOR USE OF THE SCHOOL DO NOT WRITE IN BOX BELOW

Date form rec'd by school office _____ Date medication was rec'd _____ Expiration of med _____

For CONTROLLED SUBSTANCES count number of pills in the presence of parent/guardian Number of pills rec'd _____

Name of employee verifying count _____ Signature _____ Date _____

Name of parent/guardian verifying count _____ Signature _____ Date _____

MEDICATION ADMINISTRATION LOG

Student: _____

DOB: _____

Med: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JAN																															
FEB																															
MAR																															
APR																															
MAY																															
JUN																															
JUL																															
AUG																															
SEP																															
OCT																															
NOV																															
DEC																															

Enter in box above: time given, reason code and your initials:

Reason Codes:	Print Name:	Initials:
G = Given	_____	_____
A = Absent	_____	_____
F = Field Trip	_____	_____