AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS

Valid *only* for the current school year or as designated in the Individual Education Program (IEP) or in the 504 Plan.

Exception: California Education Code 49423.5, specialized services, i.e., EpiPen, nebulizer, glucagon, insulin, diabetes care, etc., may require additional forms and instructions signed by parent or legal guardian and physician. Request *Specialized Services* forms from school.

PARENT OR LEGAL GUARDIAN

1. Parent or Legal Guardian Section

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of physician. Please refer to Legal References Governing the Administration of Medication in Schools on the reverse side of this form.

I request that designated unlicensed, trained school staff or licensed nurse assist my child in taking this prescribed medication (including prescribed over-the-counter medication). I understand that my child may not be assisted with medication at school until all requirements are met. I hereby give consent for a school nurse (or designee) to communicate with my child's prescriber and to counsel school personnel as needed with regard to my child's health. I agree to, and do hereby hold the District and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this medication. I agree to comply with district rules related to administering medication at school.

Name of Child	☐ M ☐ F Sex	Birth Date	Student Identification Number
Name of School		Grade	Teacher/Room Number

List all medications routinely taken outside of school hours: _____

I will immediately notify the school if there are any changes in medications my child is taking at school.

Signature of Parent or Legal Guardian	Date	Home/Mobile Telephone	Work Telephone

PHYSICIAN

2. Physician Section

The child named above is under my care. It is necessary for him or her to receive the following prescribed medication during school hours.

Diagnosis for which medication is prescribed _____

Name of medication (one medication per form) _____

Dosage (Be specific, i.e., milligrams, etc.) _____

Time of day to be give _____ Frequency and Indication if "as needed" _____

If "as needed" describe indications and sequence orders _____

Method of administration

ORAL	☐ Liquid	☐ Tablet	☐ Inhaler
DROPS	☐ Eye, ☐ R ☐ L	☐ Ear, ☐ R ☐ L	☐ Nostril, ☐ R ☐ L
OTHER	☐ Topical,	☐ other _____	

Precautions or side effects _____

Storage and handling

- ☐ Routine handling, medication in locked storage and administered by authorized school personnel
- ☐ On-site 72 hour disaster supply only
- ☐ It is *Medical Necessity* for child *to carry* prescription for asthma, anaphylactic shock or diabetes, and indicate:
  - ☐ Designated school personnel to administer
  - ☐ Child trained to self-administer

Stamp physician name/address below:

Additional special instructions _____

Signature of Physician	Date
Name of Physician (please print) License Number	Office telephone

Legal References: California Ed Code sections 49423 - 49423.5 and Department of Education, "Program Advisory on Medication Administration, May 2005," updated June 2012

White – School District Canary – Parent or Legal Guardian Pink – Physician or Licensed Health Care Provider

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