AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS

Valid only for the current school year

2020/2021

To be completed by Parent or Legal Guardian

Note: All medications must be prescribed, <u>including</u> 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, and name of Physician or Licensed Health Care Provider.

I request with the written approval of a physician that my child take prescribed medication (including prescribed over-the-counter medication). I understand that my child may not have nor take medication at school unless all requirements are met. I hereby give consent for a school nurse or District Administrator to communicate with my child's Physician or Licensed Health Care Provider and school personnel as needed with regard to this medication.

Child's Name	Sex	Birthdate	SS#
Name of School	**Grade**	**Teacher**	**Room #**

I have read and understand the 'Notice of Provisions' printed below. I will immediately notify the school if there are any changes in medication my child is taking at school.

Date ______ Parent or Legal Guardian Signature ______

( ) Home # ( ) Work # ( ) Emergency #

Upon written request by the parent/guardian and with the written approval of the student's physician, a student with an existing medical condition that requires frequent monitoring, testing, or treatment may be allowed to self administer this service, The student shall observe universal precautions in the handling of blood and bodily fluids.

Please review the 'Notice of Provisions' California Education Code (CEC) Sections 49423, 49480 and California Administrative Code (CAC) Title 5, 18170, listed below and on the reverse page.

California Education Code, Section 49423-Administration of Prescribed medication for pupil.

Notwithstanding the provisions of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him 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 or guardian of the pupil indicating the desire that the school district assist the pupil in matters set forth in the physician's statement.

This form must be completed with physician and parent/guardian signature before any medication can be administered at school Medication required during school hours

California Education Code 49423 allow 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 the potential for education and learning.

Medication must be in the container in which it was purchased with the pharmacy label attached, and must be prescribed for the student to whom it will be administered. No medications (including over-the-counter medications) will be given at school without a current prescription from a physician.

Student name: ______________________________ Date: ______________

School of attendance: ______________________________ Teacher/Rm: ______________

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TO BE COMPLETED BY HEALTH CARE PROVIDER

Date Student examined: ______________________________

Diagnosis: ______________________________

Medication Prescribed: ______________________________

Dosage: ______________________________

Method of administration (ie: pill, lozenge, etc.): ______________________________

Daily time schedule for administration: ______________________________

Medication administered until: ______________________________

Attach additional notes/instructions to this form

It is necessary for this medication to be taken during the school day at the time(s) indicated above and the medication may be administered by unlicensed trained school personnel.

Physician's Signature: ______________________________ License No.: ______________

Physician's Name: ______________________________ Date: ______________

Address: ______________________________ Phone: ______________

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TO BE COMPLETED BY PARENT/GUARDIAN

I authorize school personnel to administer the above medication to my child as ordered by the Health Care Provider. I also authorize the school nurse/authorized school personnel to consult the Health Care Provider named above about my child's medication needs.

Parent/Guardian: ______________________________

Printed or Typed Name: ______________________________ Date: ______________

Home Address: ______________________________

Phone: Home: ______________________________ Work: ______________

****This form must be renewed whenever the prescription changes and at the beginning of each school year.**