CENTRAL UNION HIGH SCHOOL DISTRICT- HEALTH SERVICES 351 EAST ROSS, EL CENTRO, CA 92243 PHONE (760) 336-4272
Christina Wilkinson, RN Health Services Coordinator

Parent Consent and Authorized Health Care Provider Authorization for Management of Medication Administration at School and School-Sponsored Events

* Please Return Form to Your School Nurse or School Site Office

Student:	Date of Birth:	Grade:
School:	Student ID Number:	School Year:

1. **Name of medication** (one medication per form): ____________________
   ☐ Prescription ☐ Over-the-counter (non-prescription) ☐ Controlled medication
2. **Reason for medication**: ____________________
3. **Method of administration:**
   ☐ oral ☐ g-tube ☐ nebulizer ☐ inhaled ☐ injection ☐ topical ☐ Other: ____________
4. **Amount/Dosage of medication** (be specific, i.e., ml, mg, etc.): ____________
5. **Time(s) of day to be given at school:** ____________________
   ☐ As needed **PRN** Frequency: ____________________
   List specific symptoms that would necessitate administration of the **PRN** medication and indications for referral for a medical evaluation: ____________________
6. **Possible side effects**: ____________________
7. **Additional comments**: ____________________

Authorized Health Care Provider Authorization for Management of Medication Administration in School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

☐ **In my professional opinion, the student is competent to safely carry and self-administer the above-named medication according to the condition(s) in the above written statement.**

Authorized Health Care Provider Name____________________**Signature**____________________
Phone__________**Address**____________________**City**__________**Zip**__________**Date** __________

Parent Consent for Authorization and Management of Medication Administration in School Setting

I the undersigned, the parent/guardian, of the student, request that the specialized physical health care service, medication administration be administered to my child in accordance with state laws and regulations.

1. I give consent for the school nurse, other duly qualified supervisor of health, or site administrator to communicate with the authorized health care provider and the pharmacist regarding the provider's written statement.
2. I will provide the necessary medication, supplies and equipment.
3. I will notify the school nurse, other duly qualified supervisor of health, or the site administrator if there is a change in child's medication, health status or authorized health care provider.
4. I will notify the school nurse, other duly qualified supervisor of health, or site administrator immediately and provide new consent for any changes in authorized health care provider's authorization.

☐ **I, the parent/guardian of the student, request that my child carry and self-administer his/her medication as authorized above.**

Signature of Parent/Guardian____________________**Date**__________

NOTE During early dismissal days and Extended School Year Program, Specialized Physical Health Care Procedures ordered on or after dismissal time will not be administered at school. Parent/guardian to provide at home. (Excluding "Emergency" SPHCS).

Reviewed by school nurse (Signature): ____________________Date: __________

Consentimiento de los padres y autorización autorizado proveedor de atención médica para la Gestión de la Administración de Medicamentos en la escuela y eventos patrocinados por la escuela

* Por favor devuelva el formulario a su enfermera escolar o oficina del sitio escolar

Estudiante:	Fecha de Nacimiento:	Grado:
Escuela:	ID Numero:	Eduque Año:

1. **Name of medication** (one medication per form): ____________________
   ☐ Prescription ☐ Over-the-counter (non-prescription) ☐ Controlled medication
2. **Reason for medication**: ____________________
3. **Method of administration:**
   ☐ oral ☐ g-tube ☐ nebulizer ☐ inhaled ☐ injection ☐ topical ☐ Other: ____________
4. **Amount/Dosage of medication** (be specific, i.e., ml, mg, etc.): ____________
5. **Time(s) of day to be given at school:** ____________________
   ☐ As needed **PRN** Frequency: ____________________
   List specific symptoms that would necessitate administration of the **PRN** medication and indications for referral for a medical evaluation: ____________________
   ____
   ____
6. **Possible side effects**: ____________________
7. **Additional comments**: ____________________

Authorized Health Care Provider Authorization for Management of Medication Administration in School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

☐ **In my professional opinion, the student is competent to safely carry and self-administer the medication according to the condition(s) in the above written statement.**

Authorized Health Care Provider Name____________________**Signature**____________________

Phone__________**Address**__________________**City**__________**Zip**__________**Date** __________

Consentimiento de los padres para la autorización y gestión de la administración de medicamentos en la escuela Marco

El que suscribe, el padre o tutor, del estudiante antes mencionado, solicitamos que el servicio especializado de atención de la salud física, administración de medicamentos se administran a mi hijo, de acuerdo con las leyes estatales y regulaciones.

1. Doy mi consentimiento para la enfermera de la escuela, otro supervisor debidamente calificado de la salud, o administrador del sitio para comunicarse con el proveedor de asistencia sanitaria autorizado y el farmacéutico en lo que respecta a la declaración escrita del proveedor.
2. Voy a ofrecer la necesaria medicación, suministros y equipo.
3. Voy a notificar a la enfermera de la escuela, otro supervisor debidamente calificado de la salud, o el administrador del sitio si hay un cambio en la medicación del niño, estado de salud o proveedor de cuidado de salud autorizado.
4. Voy a notificar a la enfermera de la escuela, otro supervisor debidamente calificado de la salud, o administrador del sitio inmediatamente y dar su consentimiento para cualquier nuevo cambio en la autorización de proveedor autorizado de atención médica.

☐ **Yo, el padre o tutor del estudiante arriba mencionado, solicito que mi hijo llevar y auto-administrarse su medicación según lo autorizado anteriormente.**

Firma del Padre____________________**Fecha** ____________________

*** NOTA *** Durante los días de salida temprana y Año Escolar Extendido Programa Especializado de Salud Física procedimientos ordenados a partir del tiempo de despido no se administrará en la escuela. Padre / madre / tutor para proporcionar en el hogar. (Excluyendo "de emergencia " SPHCS).

Reviewed by school nurse (Signature): ____________________ Date: __________