AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL

Name of Student	Date of Birth	Grade	School	Date

California Education Code 49423 defines certain requirements for administration of medication "…**any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse of other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which 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 the matter set forth in the physician statement."** CUSD Board Policy No. 2401 does not allow students to administer their own medication without written permission as stated above.
Additionally, CUSD Administrative Regulation No. 2401 indicates that school personnel are **prohibited** from administering any over-the-counter or prescription medications including, aspirins, vitamins, antihistamines, etc. unless the medication is accompanied with **written permission from both the parent/guardian and physician**. The medication must be clearly labeled and sent to school in a container from the pharmacy and **will be kept in the school office unless otherwise directed by the physician.**

All medication orders will be automatically discontinued at the end of the school year after summer school.
New orders are required each school year.

PLEASE RETURN THIS FORM TO YOUR SCHOOL HEALTH OFFICE

****PHYSICIAN USE ONLY****

1. Medication: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: □ **Oral** □**Inhalation** □**Nasal** □**Topical** □ **Intramuscular** □ **Subcutaneous** □**Other** _____
Medication Start Date: _____ **Stop Date:** _____
□ **If DAILY, Time (s) to be given:** _____
□ **If AS NEEDED (prn), Frequency:** □ **Every 4 to 6 hrs.** □ **Every 6 to 8 hrs.** □ **Other** _____

FOR INHALER, EPINEPHRINE AUTO-INJECTORS or other medications approved by physician only.
□ Self- Carry - **Student demonstrates competence.** □ Self- Pace PE
□ Stored in the Health Office
Other instructions or precautions-possible reactions: _____

2. Medication: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: □ **Oral** □**Inhalation** □**Nasal** □**Topical** □ **Intramuscular** □ **Subcutaneous** □**Other** _____
Medication Start Date: _____ **Stop Date:** _____
□ **If DAILY, Time (s) to be given:** _____
□ **If AS NEEDED (prn), Frequency:** □ **Every 4 to 6 hrs.** □ **Every 6 to 8 hrs.** □ **Other** _____

FOR INHALER or EPINEPHRINE AUTO-INJECTORS ONLY or other medications approved by physician only
□ Self- Carry - **Student demonstrates competence.** □ Self- Pace PE
□ Stored in the Health Office
Other instructions or precautions-possible reactions: _____

3. Medication: _____ **Dose:** _____ **Reason/Diagnosis:** _____

Route: □ **Oral** □**Inhalation** □**Nasal** □**Topical** □ **Intramuscular** □ **Subcutaneous** □**Other** _____
Medication Start Date: _____ **Stop Date:** _____
□ **If DAILY, Time (s) to be given:** _____
□ **If AS NEEDED (prn), Frequency:** □ **Every 4 to 6 hrs.** □ **Every 6 to 8 hrs.** □ **Other** _____

Physician's Name: _____ **Physician's Signature:** _____ **Physician's NPI #** _____

Address: _____ **Phone:** _____ **Date:** _____

PLEASE COMPLETE BOTH SIDES

Name of Student	Date of Birth	Grade	School	Date

****PARENT/GUARDIAN COMPLETES THIS PAGE****

Parent Request For Assistance with Medication at School

Responsibility of the Parent or Guardian

1. **Parents/guardians shall be encouraged to cooperate with the physician to develop a schedule so the necessity for taking medications at school will be minimized or eliminated.**
2. **Parents/guardians will assume full responsibility for the supply and transportation of all medications.**
3. **Parents/guardians may administer medication to their child on a scheduled basis arranged with the school. Students are not permitted to carry prescribed or over-the-counter medication on school campus.**
4. **Parents/guardians may pick up unused medications from the school office during and at the close of the school year. Medication remaining after the last day will be discarded.**
5. **Each medication is to be in a separate pharmacy container prescribed for the student by a California licensed health care provider.**
6. **Each over-the-counter medication is to be in its original sealed container and prescribed for the student by a California licensed health care provider.**

The parent or guardian must complete this page before any medication (prescription or over-the-counter) can be given, or taken, at school. <u>This form must be renewed at the beginning of each school year or with any change in medication.</u>

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of medications accompanied by appropriate physician instructions).

All medication orders will be automatically discontinued at the end of the school year-summer school. New orders are required each school year.

A. For MEDICATIONS KEPT IN THE SCHOOL HEALTH OFFICE only: I hereby request that the staff of my child's school assist in giving medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.

Signature of parent or guardian: _____ **Date:** _____ **Phone Number:**_____

B. For Medication SELF CARRY only: I hereby request that my student carry and self-administer his/her medication as ordered by his/her physician. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication. I also give permission to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: _____ **Date:** _____ **Phone Number:**_____