

AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS

Valid only for the current school year

Part 1: To be completed by Parent or Legal Guardian

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, and name of licensed health care provider.

I request that designated school personnel assist my child in taking this 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 the school nurse or administrator to communicate with the licensed health care provider and school personnel as needed on matters related to this medication.

_____ MF _____
Child's Name Sex Date of Birth Name of School Grade/Teacher

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

_____ X _____ () _____ () _____
Date Parent or Legal Guardian Signature Home Phone Work Phone

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

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/her by a physician, may be assisted by the district 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.

California Education Code, Section 49480-Continuing medication regimen for nonepisodic condition; required notice to school employees

The parent of legal guardian of any public school pupil on a continuing medication regime for a nonepisodic condition shall inform the district nurse or other designated certificated school employee of the medication being taken, the current dosage, and the name of the supervising physician. With the consent of the parent or legal guardian of the pupil, the district nurse may communicate with the physician and may counsel with the school personnel regarding the possible effects of the drug on the child's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects, omission, or overdose. The superintendent of each school district shall be responsible for informing parents of all pupils of the requirements of this section.

California Administrative Code Title 5, 18170-The agency shall follow these provisions pertaining to medication

1. An assigned staff member shall administer medications prescribed by a physician for a child provided written parental consent has been given.
2. Record of medication dosages to the child and date and time medication is administered shall be maintained by the facility.
3. Centrally stored medicines shall be kept in a safe and locked place that is not accessible to persons other than employees responsible for health supervision. Each container shall carry the name of the medication, the name of the person for whom prescribed, the name of the prescribing physician and the physician's instructions. All centrally stored medications shall be labeled and maintained in compliance with State and Federal laws. Each person's medication shall be stored in its originally received container.

No medications shall be transferred between containers. The agency shall be responsible for assuring that a record of centrally stored prescription medications for each person in care includes: the name of the person for whom prescribed, the drug name, strength and quantity, the date filled, the prescription number and name of issuing pharmacy.

4. All medications shall be centrally stored in an area that is totally inaccessible to children.

**Procedures under the Individualized Education Program (IEP), Individualized Health Program (IHP) or 504 Plan should not be addressed on this form. Please request form for Specialized Physical Health Care Services pursuant to California Education Code Section 49423.5*

(See reverse of form)

Part 2: To be completed by the health care provider

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

Name of Child (Print) _____

Diagnosis for which medication is prescribed _____

Name of medication (*one medication per form*) _____

Dosage (*Be specific, i.e., milligrams, etc.*) _____ Start date: _____ End Date: _____

Time of day to be given _____ Frequency 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
Topical Other _____

Precautions, reactions, or side effects _____

For Severe Allergy:

If the following symptoms occur (check appropriate):

- | | |
|--|--|
| <input type="checkbox"/> choking | <input type="checkbox"/> hives |
| <input type="checkbox"/> skin rash | <input type="checkbox"/> swelling (<i>eyes/lips</i>) |
| <input type="checkbox"/> loss of voice | <input type="checkbox"/> breathing difficulty |
| <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> other _____ |

Use: Epi-pen Jr. Epi-pen

Transport student to nearest emergency room

Storage and Handling

Routine handling, medications in locked storage and administered by authorized school personnel

72 hour disaster supply only

Refrigeration

_____ Initial here if student is authorized to carry, and is able to self-administer prescription for **asthma** or **diabetes** independently.

_____ Initial here if student is authorized to carry, and is able to self-administer auto-injectable **epinephrine** independently.

Additional special instructions _____

Health care provider (Printed Name)

Date

Signature

Office Address

Office Phone

Office Fax

SCHOOL PERSONNEL: Provide a copy of this form to the school nurse and place the original in the medication log.

(See reverse of form)