AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS

Valid *only* for the current school year or as designated in the Individualized Education Program (IEP) for Special Education students.

Please review the **'Notice of Provisions' California Education Code (CEC) Sections 49423, 49423.5, 49480 and California Administrative Code (CAC) Title 5, 18170,** printed on the reverse side of this form.

Part 1: To be completed by Parent or Legal Guardian

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, and name of Physician or 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 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 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.

_____ M F _____ _____ _____

Child's Name | Sex | Birthdate | SS# | ID#

_____ _____ _____ _____

Name of School | Grade | Teacher | Room Number

Please list *only* any other medications routinely taken *outside* of school hours _____

I have read and understand the 'Notice of Provisions' printed on the reverse side of this form. 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 | Emergency Phone

Part 2: To be completed by the Physician or Licensed Health Care Provider

The child named above is under my care. It is necessary for him or her to receive the following 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 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**
OTHER ☐ Topical or ☐ _____

Precautions, reactions, or side effects _____

Stinging Insect Allergy only: If the following symptoms occur (check appropriate):
☐ choking ☐ hives ☐ skin rash ☐ swelling (eyes and lips) ☐ loss of voice ☐ breathing difficulty ☐ loss of consciousness
☐ other _____
Use: (circle one) Epi-pen Jr. or Epi-pen as directed
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

Medically necessary ☐ Child to carry, school personnel to administer ☐ Child trained to carry and self-administer
(Inhalers ONLY)

Additional special instructions/interventions _____

_____ _____ _____

Date | Physician or Licensed Health Care Provider (Printed Name) | Signature

_____ _____ _____

Office Address | Office Phone | Office Fax

***SCHOOL STAFF: Notify school nurse or district administer if allergy or asthma is indicated under diagnosis.**