

Authorization to Administer Medication

Student Medication – Legal Reference: Education Code Section 49423 “...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 or other designated school person, if the school district received (1.) a written statement from such a physician detailing the name of the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matter set for in the physician’s statement.” No other medication is to be administered by school personnel. This includes all medication available without prescription. **Medication is to be delivered in the original container labeled with the name of the student, name of the prescribing physician, name of the medication and instruction. Over the counter medications must be in their original container and be authorized by the parent and physician. This form must be completed for both prescription and over-the counter medications. It is the parent’s responsibility to update this form as needed.**

Student _____ Grade _____ Teacher _____ Date _____

Parent _____ Phone(s) _____

Health Care Provider _____ Phone _____

1.	Medication(s)	Dosage	Frequency/Indication	Duration	Possible Side Effects
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

2. Additional Information and/or Precautions regarding medications or student’s condition. Please include Indications for “as needed” Medication:

3. HEALTH CARE PROVIDER: I am a physician actively licensed by the State of California. Attached hereto is a prescription for the medication/treatment specified above.

PHYSICIAN’S SIGNATURE: _____ **Date:** _____

4. I am the parent/guardian of the above student and I have lawful custody of said child. I hereby give consent to appropriate District personnel to administer or assist in administering medication(s) and/or treatment as specified by his/her Health Care Provider. Furthermore, I hereby give consent to the School Nurse to receive from, or send to, the Health Care Provider any information concerning my child’s medication or the medical condition.

Parent/Guardian’s Signature _____ **Date:** _____

5. AUTHORIZATION TO CARRY EMERGENCY MEDICATIONS SUCH AS ASTHMA INHALERS AND EPI-PENS:

Complete this section only if the student needs to carry and self-administer emergency medications such as asthma inhalers, Epi-Pens or other urgently needed medication. Item #1 above must also be completed listing the medication(s), dose, frequency, indications, and side effects.

A. Student: I certify that I have read and understand the instructions regarding the self-administration of my emergency medication(s). I agree to take these above described medications in compliance with my Health Care Provider’s instructions. I understand the consequences of using the medication incorrectly or inconsistently or of sharing the medication with others. I will report problems with the medication, supplies or equipment immediately to the school nurse.

Student’s Signature _____ **Date:** _____

B. Parent/Guardian: My child has been instructed in the proper dosage and administration of the above medication and has demonstrated the ability to self-administer it. We/I (Parent/Guardian) request that s/he be permitted to self-administer it as directed by our Health Care Provider in compliance with District policy and procedures.

Parent/Guardian Signature _____ **Date:** _____

C. Physician Approval: The student has been properly trained and is able to self-administer his/her asthma inhaler or Epi-Pen.

Physician Signature _____ **Date:** _____