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

This form must be renewed whenever the prescription changes and at the beginning of each school year.

The child below is under my care and it is necessary for the child to receive this medication during school hours.

Name of Child_____ **Birthdate**_____

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_____

For Severe Allergy: 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., Epi-pen, or Ana-Kit 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

If Medically Necessary Child to carry, school personnel to administer Child trained to carry and self-administer

Additional special instructions/interventions_____

I understand that this medication will be administered by a non-licensed school personnel designated by the school principal and trained by the credentialed school nurse (RN).

_____ _____ _____

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

_____ _____ _____

Office Address Office Phone Office Fax

Reviewed and approved by School Nurse (signature) : _____ Date: _____

AUTHORIZATION FOR MEDICATION TAKEN DURING SCHOOL HOURS

This form must be renewed whenever the prescription changes and at the beginning of each school year.

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 California Physician or California 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 understand that this medication may be administered by a non-licensed school personnel designated by the school principal and trained by the credentialed school nurse (RN). I hereby give consent for a School Nurse or District Administrator to communicate with my child's California Physician or California Licensed Health Care Provider, and school personnel as needed with regards to this medication.

California Education Code, § 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 by a physician, may be assisted by the school 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, § 49480 – Continuing Medication Regimen for Non- episodic Condition- The parent or legal guardian of any student on a continuing medication regimen for a nonepisodic condition shall inform the school 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 student, the school 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. School Administration shall be responsible for informing parents of all pupils of the requirements of this section.

I hereby give my permission for my child (named above) to receive medication in accordance with school policy regarding Administering Medications to Students. All medications, including over-the-counter products, have been prescribed by a licensed health care provider. Medications will be furnished in current pharmacy-labeled bottles with identifying information and brought to school by parent/guardian. I assume full responsibility for informing the school of any change in my child's health and/or medication. I agree that medication dosage cannot be changed without a physician's order. Further, I hereby release the school and their agents and employees from all liability that may result from my child taking the prescribed medication.

NOTE: I understand some emergency medications may be self-carried and administered. Additionally, scheduled medication may be self-administered under supervision while traveling on a field trip. If appropriate, I consider my student to have the maturity and knowledge to self-administer his/her medication and understand that the school system can assume no liability for monitoring the self- administration. I assume the responsibility for ensuring that my child is carrying and taking their medication as ordered. Prior to acceptance of a self-administered medication on campus, the school nurse must ascertain the student's maturity and knowledge, as well as review/ensure compliance with school. Schools may revoke this privilege if the student proves to be irresponsible or incapable. With these facts in mind, I give permission for my child to self-administer medication: Yes _____ No _____

_____ M F _____ _____ _____

Child's Name Sex Birthdate SS# Grade

_____ _____ _____

Date Parent/ Legal Guardian Name Parent/ Legal Guardian Signature

Procedures under the Individualized Education Program (IEP) for special education students should not be addressed on this form.