Escondido Union High School District

Authorization for Medication Administration *(Education Code Section 49423)*

This Form Valid for School Year

School___________________ Phone _________________ Fax ___________________

The procedure covering prescription and non-prescription medication listed on this form will be expedited under the following conditions:

1. Only medication prescribed by the pupil's physician, as being necessary to be taken by the pupil in the manner listed on this form should be brought to school. (Written parent permission also required.)
2. Such medication should be taken by the pupil in accordance with instructions from the physician as listed on this form.
3. Medication brought to school to be given to the pupil according to the provisions listed on this form should be in the prescription containers which are clearly labeled by pharmacist with the name of the pupil; the name of the prescribing physician; the druggist who dispensed the medication or the manufacturer; and the amount of medication to be taken at specified times or in specific situations, etc. (Parents may want to ask the physician for a duplicate supply, one for home and one for school)
4. All medication will be kept in a secure place. Any special instructions for storage or security measures of any medication should be written by the physician and given to school personnel so that such instructions can be followed.
5. Parent only shall deliver the medication and the completed form to the school health office.
6. A new medication authorization must be renewed for each school year if a continuance of medication is necessary.

This portion to be completed by a Parent/ Legal Guardian

I, the undersigned, as legal parent/guardian of (*student name*)____, whose birth date is ______/_____/______, and is attending (*school*) ____________________request that the following medicine(s) ___________________ ____ be made available to my child at the times prescribed ________________________.

- I understand that only designated personnel will assist my child in taking the medicine(s) as directed by my physician. I will provide a written statement from a physician detailing method, amount and time medication is to be taken.
- I will provide the medicine(s) in the prescription container(s) which is labeled with the name of my child, the prescribing physician name, and amount of medication prescribed.
- If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Prescription and non-prescription medications are not permitted to be taken at school without a written statement from the physician and a written statement from the parent indicating desire that the district assist the student as set forth in the physician's statement below.

For Asthma Inhaler/Epi-Pen use only:
I permit my child to carry the above listed inhaler/ Epi-Pen as ordered by his/her physician.
I understand that sharing medication with other students will result in disciplinary action.
Parent/Guardian Signature_______________________________
Date _______________

I recognize the fact that this is a service or accommodation, which the school is not legally required to perform. I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

Parent/ Guardian Signature ____________ Date ____________

Home Address ____________

Work Telephone ____________ Home Telephone ____________

This portion to be completed by a physician licensed in the State of California

Medication	Method of administration	Dosage	*Time of day *Allow 30 min. before or 30 min. after written time	Reason	Discontinue on

For Inhaler/Epi-Pen use only: Patient has been instructed in the proper use of Inhaler/Epi-Pen. The patient's well-being is in jeopardy unless the inhaler/Epi-Pen is carried on his/her person; therefore, I request that he/she be permitted to carry the inhaler/Epi-Pen . He/She understands the purpose, appropriate method, and frequency of use of this inhaler/Epi-Pen.

Date _____________ **Physician Signature** ________________________________

Type of Assistance for Administering Medication (nurse to administer, self-administer, Observe, measure, etc.) _________________

Precautions for Administration or Storage of Medication ____

Do you wish to have school nurse or health clerk contact you at intervals to discuss this medication? o Yes o No

____ M.D. _________________________ _____________________________________

Printed Name of Physician | Medical License Number | Telephone Number

____ _____________________________________

Signature of Physician | Date