Sierra Unified School District – Health Services
29143 Auberry Road, Prather, CA 93651 Phone: 559-855-3662 FAX 559-855-3585

AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL

Name of Student:	Date of Birth:	Grade:	School:	School Year

PLEASE RETURN THIS FORM TO YOUR SCHOOL NURSE

California Education Code 49423 defines certain requirements for administration of medication "… 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 of other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which medication is to be taken, and (2) a written statement form the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician statement." School Personnel are prohibited from administering any over the counter or prescription medications including, aspirins, vitamins, antihistamines, etc. unless the medication is accompanied with written permission from both the parent/guardian and physician. The medication must be clearly labeled and sent to school in a container from the pharmacy and will be kept in the school office unless otherwise directed by the physician.

All medication orders will be automatically discontinued at the end of the school year after summer school.
New orders are required each school year.

**********PHYSICIAN USE ONLY**********

Medication: _____ Dose: _____ Reason/Diagnosis: _____
Route: (Circle) Oral Inhalation Buccal Topical Intramuscular Subcutaneous GTube
Other: _____ **Medication Start Date:** _____ **End Date:** _____
If DAILY, times to be given: _____
If AS NEEDED (prn) Frequency: _____

FOR INHALER, or EPINEPHRINE AUTO-INJECTORS or other medications approved by physician only:
Student is allergic to: _____
(Indicate one): Self Carry (student demonstrates competence) Stored in Health Office Stored in locked classroom cabinet Other: _____
Other instruction or precautions – possible reactions: _____

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AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL – CONTINUED

Name of Student:	Date of Birth:	Grade:	School:	School Year

**************************PARENT/GUARDIAN COMPLETE THIS PAGE**************************

Parent Request for Assistance with Medication at School

The parent or guardian must complete this page before any medication (prescription or over-the counter) can be given, or taken, at school. **This form must be renewed at the beginning of each school year or with any change in medication.**

Responsibility of the Parent or Guardian:

1. Parents/Guardians shall be encouraged to cooperate with the physician to develop a schedule so the necessity for taking medications at school will be minimized or eliminated.
2. Parents/Guardians will assume full responsibility for the supply and transportation of all medications.
3. Parents/Guardians may administer medication to their child on a scheduled basis arranged with the school. Students are not permitted to carry prescribed or over-the-counter medication on school campus.
4. Parents/Guardians may pick up unused medications from the school office or from classroom staff at the close of the school year. Medications remaining after the last day will be discarded.
5. Each medication is to be in a separate pharmacy container prescribed for the student by a California licensed health care provider.
6. Each over-the-counter medication is to be in its original sealed container and prescribed for the student by a California licensed health care provider.

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of inhalers and epinephrine autoinjectors accompanied by appropriate physician instructions). All medication orders will be automatically discontinued at the end of the school year – summer school. New orders are required each school year.

A. For MEDICATIONS KEPT IN THE SCHOOL HEALTH OFFICE/LOCKED CABINET IN CLASSROOM ONLY: I hereby request that the staff of my child's school assist in giving medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.
Signature of Parent/Guardian: _____ Date: _____ Contact #: _____

B. For INHALERS/EPINEPHRINE AUTO-INJECTORS SELF CARRY or other medications approved by physician ONLY: I hereby request that my student carry and self-administer his/her inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication. I also give permission to contact the physician for consultation and exchange information as needed.
Signature of Parent/Guardian: _____ Date: _____ Contact #: _____