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 medication, 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 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 a prescription. **Medication is to be delivered in the original container labeled with the name of the student, name of prescribing physician, name of medication and instructions. 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)	Dose	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 medications(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's 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**_____

AUTORIZACIÓN PARA ADMINISTRAR MEDICINAS

MEDICINAS PARA ALUMNOS Referencia Legal: Código Educacional Sección 49423
«...cualquier alumno que debe tomar medicina recetada por su médico durante el dia escolar, puede obtener la ayuda de la enfermera escolar u otro personal escolar designado, si el distrito escolar ha recibido (1) declaración escrita del médico detallando el nombre de la medicina, método, dosis y horario de administración de tal medicamento, y (2) una declaración escrita del padre o guardian del alumno indicando su consentimiento para que el distrito escolar asista al estudiante a tomar la medicina de acuerdo con las instrucciones del médico.» Ningun otro medicamento puede ser administrado por el personal escolar. Esto incluye medicamentos disponibles sin receta.
Las medicinas se deben mandar a la escuela en el envase original claramente marcado con el nombre del estudiante, nombre del médico quien lo autoriza, nombre de la medicina e instrucciones. Favor de completar y adjuntar este formulario también. ***Favor de notar que es la responsabilidad de los padres de estar seguros que la información en este formulario esté al corriente.***

Estudiante _____ **Grado** ____ **Maestro/a** _____ **Fecha** _____

Padre/Madre _____ **Teléfono** _____ **o** _____

(*La sección de abajo debe ser completado por el médico*)

** **Health Care Provider** _____ **Telephone** _____

1. **Medications**	**Dose**	**Frequency**	**Duration**	**Possible Side Effects**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. **Additional Information and/or Precautions** regarding medication or student's condition:

_____

3. Soy el/la Padre/Guardian del estudiante nombrado arriba y tengo custodia legal de él/ella. Por medio de esto doy mi permiso al personal apropriado del Distrito en administrar o ayudar en la administracion de medicamentos y/ o tratamiento como es especificado por su médico. Además, doy consentimiento al distrito para recibir de o mandar a este proveedor de salud cualquiera información acerca de la condición de salud de mi hijo/a.

Firma de Padre/Madre/Guardian: _____ **Fecha** _____

4. Si el estudiante puede administrar medicamentos por sí mismo, hay que llenar este contrato:

AUTORIZACIÓN PARA AUTO-ADMINISTRACIÓN:

A. **Estudiante**: Certifico que he leido las instrucciones acerca de la autoadministración de mi(s) medicina(s). Estoy de acuerdo con tomar estas medicinas nombradas arriba según las recomendaciones del médico.

Firma del Estudiante: _____ **Fecha** _____

B. **Padre/Madre/Guardian**: Mi hijo/a ha sido instruido en la administración y dosis correcta de las medicinas(s) nombrada(s) arriba y ha demostrado la habilidad de autoadministrarsela(s). Nosotros/Yo (Padre/Guardian) pedimos que el/ella tenga permiso de administrarse la(s) medicina(s) a sí mismo según las instrucciones de nuestro médico y las reglas del Distrito.

Firma de Padre/Madre/Guardian: _____ **Fecha** _____

4. ****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.**

[ ] * initial here if student has been properly trained and is able to self-administer

Physician Signature _____ **Date** _____