

SOUTH BAY UNION SCHOOL DISTRICT
AUTHORIZATION FOR MEDICATION AT SCHOOL
(Calif. Ed. Code 49423)

Child's Name _____ Birth Date _____

School _____ Teacher _____ Track _____ Grade _____

Dear Parent:

To protect your child and other children in school, medication is allowed at school only with written orders from the California licensed health care provider who prescribed the medication and signed permission from you. An updated permit must be submitted each school year.

Please have your child's California licensed health care provider complete the form on the reverse side. Return this form with your signature and your child's medication to the school office. All medication will be stored in the school office.

TO BE COMPLETED BY THE PARENT

I understand this is a service the school district is not legally required to perform.

I agree to hold the school district, its officers or employees, harmless from all liability, suits or claims, or whatever nature, or kind, which might arise out of these arrangements.

I request the school principal, or his designee, to administer the medication as directed by the California licensed health care provider on this form. I agree that my child will not keep any medication in his possession while at school. My child will be responsible to come to the office for his medication at the prescribed time. The medication which will be furnished by me will be sent in a suitable container which has the child's full name, name of the medication, dosage, number of doses sent, name of licensed health care provider and name of the drug store where medication was obtained. If the school has any question about this medication or its administration, they may call me during school hours at _____ and my licensed health care provider _____ at _____.

Name

Phone

PARENT/GUARDIAN

DATE

FOR STUDENT WITH ASTHMA

MY CHILD WILL BE RESPONSIBLE FOR CARRYING HIS RESPIRATORY INHALER WITH DOCTOR AUTHORIZATION AND WILL SELF-ADMINISTER. MY CHILD AGREES TO FOLLOW THE DISTRICTS PROCEDURES CONCERNING THE HANDLING AND ADMINISTRATION OF THIS MEDICATION.

PARENT/GUARDIAN

DATE

STUDENT'S NAME _____

BIRTHDATE _____

TO BE COMPLETED BY A CALIFORNIA LICENSED HEALTH CARE PROVIDER

a) Nature of condition requiring medication at school _____

<u>Name of Medication</u>	<u>*Method of Administration</u>	<u>Dosage</u>	<u>Approximate Time of Day</u>	<u>Date to be Discontinued</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

c) If medication is prescribed PRN (AS NEEDED) please describe conditions under which medication should be used, how often can it be repeated, etc.

d) What adverse reactions should we watch for? _____

e) If adverse reaction occurs, please indicate what emergency action you recommend.
IMPORTANT TO NOTE The school nurse may not be on site and most school staff are not medically trained.

*Only a licensed school nurse or any employee willing to assume this responsibility and who has had some training or experience, may administer medication by injection at school under the following conditions:

- 1) A valid emergency must exist.
- 2) The medication, equipment and authorization for administration be provided by the parent and licensed health care provider.

f) FOR INHALED MEDICATIONS

I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.

It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

g) CALIFORNIA LICENSED HEALTH CARE PROVIDER'S SIGNATURE _____

Telephone Number _____ Address _____

Date _____ Fax # _____