Medication at School Form

To be renewed at the beginning of each school year and when changes in medication or authorized health care provider occur.

Student Name: ____ Date of Birth: ______________
Last First M.I.

Student ID#: ______________ School: _________________ Grade/Room #: ____________

California Education Code, Section 49423 defines 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 or 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 from 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's statement**."

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Diagnosis or Reason for Medication during the school day: ______________________________________

Name of Medication	*Dose*	*Route*	*Time(s) to be Given*
________________	________	________	________
________________	________	________	________
________________	________	________	________

Possible **side effects** or other serious considerations regarding medication(s): ____________________________

FOR **AUTO-INJECTOR EPINEPHRINE (EpiPen):**

Student is allergic to: ____

Student **may** carry EpiPen and self-administer ☐ Yes ☐ No (If yes, check statement below)

FOR **ASTHMA INHALERS**:

Student **may** carry asthma inhaler and self-administer ☐ Yes ☐ No (If yes, check statement below)

Does student need the prescribed medication ______ minutes before physical activity or sports? ☐ Yes ☐ No

☐ ***I have instructed the student in the proper method to use his/her ☐ asthma inhaler and/or ☐ EpiPen and in my opinion the student is competent to safely self-administer the medication at school.***

____ **Date:** ____________________
Health Care Provider Signature

____ **Phone:** ____________________
Health Care Provider Name / Address (Please Print)

PARENT REQUEST AND AUTHORIZATION:

I request that the school nurse or designated school personnel assist my child with medication as ordered by the health care provider. I give permission for the school nurse to communicate with the health care provider on matters related to this medication. I will notify the school nurse of any changes in medication, health status, or authorized health care provider and will provide a new medication order form. I understand I may submit a written statement to withdraw my consent for administration of medication at school at any time.

I understand that the school must receive the medication in a container with a pharmacy label that indicates name of student, health care provider's name, medication, dose, route, and time to administer (over-the-counter medication must be in the original container). I understand that the medication must be delivered to the school by the parent, guardian, or adult designee.

I understand that medication (including over-the-counter) can only be administered to my child at school if the school has received ALL of the following: a.) Current California-authorized health care provider order, b.) Parent / guardian signature, and c.) Properly labeled medication.

PARENT/GUARDIAN SIGNATURE: ____ **DATE:** ____________