72 Hour Disaster Medication

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 personnel, 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 sent in the original container labeled with the name of the student, name of prescribing physician, name of medication and instructions. This form must be completed and included. 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	Duration	Possible Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

_____

3. 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 District to receive from, or send to, the health care provider any information concerning my child's medical condition.

Parent/Guardian Signature_____ **Date**_____

attached hereto is a prescription for the medication/treatment specified above..

4. **Complete this section for medications which student may self-administer:

AUTHORIZATION FOR SELF-ADMINISTRATION:

A. **Student:** I certify that I have read and understand the instructions regarding the self-administration of my medications(s). I agree to take these above described medications in compliance with my health care provider's recommendations.

Student 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 Signature_____ **Date**_____

5. **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**_____

Please Print/Stamp Physician Name, Address, Phone here:

Distribution:
Original - File Copy– Teacher & School Nurse