Ross School District

Authorization to Administer Medication

School Year 2017-2018

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/Physician_____ 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.

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_____