# San Marino Unified School District
# Administration of Medication Form

**Part I: ORDER FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY/FIELD TRIPS**
In accordance with California Education Code section 49423, this form must be completed by authorized California healthcare provider and be on file for any student who requires medication(s) during the regular school day.

Student: Last Name _____ First Name _____ Middle Initial _____ DOB: month/day/year _____

Grade _____ School _____ (626) _____ (phone) (626) _____ (fax)

Karen Gines, R.N. (626) 299-7000 x1385 (District Nurse: Name and Phone Number)

**TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER:**
(California licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants – California Code of Regulations, Title 5, section 601[a])

A. **Nature of condition** requiring medication during the regular school day: _____

_____

| Name of Medication | Method of Administration | Dosage | Amount | Time to be given | Frequency |
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B. Discontinue medication on (date):_____

C. Student is authorized to carry, and is able to self-administer, prescription for asthma or diabetes (authorized licensed healthcare provider initials: _____).

D. Student is authorized to carry, and is able to self-administer, auto-injectable epinephrine independently (authorized licensed healthcare provider initials: _____).

Authorized Healthcare Provider Name (print) _____ Signature _____ Date _____

License Number _____ Phone Number _____ Fax Number _____

**SEE NEXT PAGE FOR ADDITIONAL REQUIRMENTS**

**Parental Authorization**

I authorize the school nurse or other licensed healthcare provider (RN, LVN) designated by the responsible administrator, to administer the medication as directed by the authorized healthcare provider. I understand that the school nurse has my permission to communicate with the prescribing licensed health care provider on the matters related to this medication.

| Parent/Guardian Name (print) | Signature | Cell Number | Date |
|---|---|---|---|

| Reviewed by District Nurse (print) | Signature | Date |
|---|---|---|

## Part II: ORDER FOR DELEGATION OF ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY/FIELD TRIP

**WHEN BEING ADMINISTERED BY AN UNLICENSED VOLUNTEER SCHOOL EMPLOYEE:** The prescribing California authorized licensed healthcare provider is delegating the administration of the medication ordered above to the identified unlicensed volunteer school employee who has agreed to administer the medication. **The licensed health care provider delegating to a designated, trained unlicensed volunteer school employee will complete the delegation authorization section below.**

I voluntarily agree to administer the medication as directed by the delegating authorized healthcare provider. I understand that I may communicate with the authorized delegating healthcare provider on matters related to the medication. My signature below affirms that I have successfully completed training to administer the medication. I understand that I may revoke my agreement to administer the medication at any time, for any reason, and will not be penalized by my employer for such revocation.

| Volunteer School Employee Name | Signature | Cell Number | Date |
|---|---|---|---|

| Delegating Healthcare Provider Name | Signature | Date |
|---|---|---|

I authorize the unlicensed volunteer school employee identified in this section to administer the medication as directed by the delegating healthcare provider on matters related to this medication.

| Parent/Guardian Name | Signature | Cell Number | Date |
|---|---|---|---|

| District Nurse | Signature | Date |
|---|---|---|