EL RANCHO UNIFIED SCHOOL DISTRICT
STUDENT SERVICES

AUTHORIZATION TO ADMINISTER OR ASSIST WITH MEDICATION AT SCHOOL

California Education Code, Section 49423 may allow the school nurse or other designated school personnel to administer or assist a student with medication prescribed or ordered by an authorized health care provider during the school day.

STUDENT NAME _____ BIRTHDATE _____ SEX _____

SCHOOL _____ GRADE _____ CLASS _____

SECTION TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER LICENSED BY STATE OF CALIFORNIA

Diagnosis _____

Medication _____

Dose Form _____ Amount _____ Time _____

Method of administration _____ Administer until _____

Specify symptoms necessitating administration of medication _____

Allowable frequency _____

Indications for medical evaluation _____

Precautions or adverse side effects _____

_____

The above named student must take this medication during school hours.

Print Health Care Provider _____

Health Care Provider Signature _____

Address _____

_____

Phone _____

SECTION TO COMPLETED BY PARENT/GUARDIAN

In order to enable administration or assistance with medication, the parent/guardian must provide the Authorization to Administer or Assist with Medication at School. The Authorization to Administer or Assist with Medication at School must be updated annually, when there is a new prescription or changes in the prescription. Medication must be brought to school by a parent/guardian or designated adult and must be in an original container properly labeled by the pharmacy. No other container will be accepted. Over-the counter medication will not be given at school without an authorized Health Care Provider's order. Parent/guardian must provide all necessary supplies and equipment required to administer or assist the student with medication.

I authorize school personnel to administer or assist with the above medication to my child as ordered by the Health Care Provider. I authorize designated staff to communicate with the Health Care Provider/Pharmacist, as may be necessary, regarding question that may arise with the authorized Health Care Provider's written statement or medication. I may terminate the Authorization to Administer or Assist with Medication at School at anytime.

Parent/Guardian Signature _____ Date _____

Primary Phone _____ Other Phone _____

Reviewed 10/2015

Distribution: Medication Envelope, Health Folder, Parent