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 Name School Phone Number School Fax Number

____
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

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 provder on the matters related to this medication.

Parent/Guardian Name (print) Signature Cell Number Date

Reviewed by School 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