# Authorization for Medication

(Valid only for the current school year or whenever there is a change in medication, dose, time, or route)

Dear Parent/Guardian:

Please read this form carefully. You will need to submit it as soon as possible if your student needs to take medication during school hours. BOTH pages must be fully completed.

The School District recognizes that it may be necessary to have medication given to a student during regular school hours, and we are prepared to assist in that need. It is preferable, however, that the parent and the physician work together to devise a schedule of giving medication at home, outside of school hours whenever possible. A parent may come to school to administer medication to their child on a scheduled basis, if desired. Please make such arrangements with the school staff.

**IMPORTANT**: Parents/guardians shall provide medications, including over-the-counter, in properly labeled, original containers along with the physician's instructions. For prescribed medication, the container shall bear the name and telephone number of the pharmacy, the student's identification number, name and phone number of the physician, and physician's instructions. Medications that are not in their original container shall not be accepted or administered. Medications shall be delivered to the school by the parent/guardian, unless the Superintendent or designee authorizes another method of delivery. When the district has received written orders from the student's physician and written permission from the parent/guardian, the school nurse or other designated personnel, under supervision of the EUSD school nurse, shall assist the student in taking the medication. Parents/guardians may request in writing that their child be allowed to self-administer, monitor, or treat their existing medical condition. The parent/guardian shall also provide a written statement from the student's authorized health care provider, as specified above. The statement shall acknowledge that the student is capable of self-administering the medication and the student's health care provider has trained the student in self-administration. (CA Education Code 49423; EUSD Board Policy 5141.21)

**Part 1: To be completed by Parent or Legal Guardian**

I authorize that the school nurse or designated trained school personnel assist my child in taking their medications and/or treatments. I understand that my child may not have nor take medication at school unless all requirements are met. I hereby give consent for a School Nurse or District Administrator to communicate with my child's physician and school personnel as needed with regard to this medication. I also agree that the District employees shall not be held liable for any loss, damage, injury, or liability of any kind to any person caused or arising from acts omissions or negligence of the District, its officers, employees, and agents related to this administration of medication to my child.

_____ | _ Female | _ Male | _ Non-binary _____ _____ _____

Student's Name Date of Birth Grade School

I have read and understand the provisions printed above. I will immediately notify the school if there are any changes in medications my child is taking at school.

_____ _____ _____ _____ _____

Date Parent/Guardian Signature Home Phone Work Phone Emergency Phone

_____ Please place your initials on the line if you **consent to your child self-administering medication,** monitoring, or treating their existing medical condition and confirm that your child's health care provider has trained your child in self-administration.

*Parent/guardian may terminate this consent at any time by submitting such termination in writing.

## ATTENTION: PHYSICIAN/MD MUST COMPLETE PAGE TWO

**FOR PHYSICIAN/MD ONLY**

**Part 2: To be completed by the Physician** (Must be licensed in California)

The student named above is under my care. It is necessary for them to receive the following medication/s during school hours.

| **Name of Medication or Treatment** | | |
|---|---|---|
| **Reason** | | |
| **Dosage** | | |
| **Route** | | |
| **Time** | | |
| **Refrigerate? (Y/N)** | | |
| **Self-Administer? (Y/N)** | ❑ No<br>❑ Yes, supervised<br>❑ Yes, unsupervised<br><br>❑ No<br>❑ Yes, supervised<br>❑ Yes, unsupervised<br><br>❑ No<br>❑ Yes, supervised<br>❑ Yes, unsupervised | ❑ No<br>❑ Yes, supervised<br>❑ Yes, unsupervised |
| **Self-Carry (Y/N)** | | |

Please initial here to confirm that the student is capable of self-administering the medication and that his/her health care provider has trained the student in self-administration. _____ (initials) _____ (Print Name and Title)

Diagnosis/Significant Findings: _____

Precautions, reactions, or side effects: _____

Allergies (Medications or Other Substances): _____

**For Severe Allergy:** If the following symptoms occur (check appropriate):

- ❑ Choking
- ❑ Hives
- ❑ Skin rash
- ❑ Swelling (eyes and lips)
- ❑ Loss of voice
- ❑ Breathing difficulty
- ❑ Loss of consciousness
- ❑ Other: _____
- ❑ **Use: (circle one) Epi-pen Jr. or Epi-pen (order must also be written above)**
- ❑ Transport student to nearest emergency room

**Additional special instructions/interventions:** _____

_____ Physician/Office Stamp Required:

_____ ____

Signature Physician

_____

Print Physician Name

_____

Office Address

_____ _____

Office Telephone Office FAX **FORM MAY BE FAXED TO SCHOOL BY PHYSICIAN.** SCHOOL FAX NUMBER:
510-601-4913
ATTN: Keegan Roehr, District Nurse

## EUSD OFFICE USE ONLY:

Date Form Received: _____

Initials: _____

- ❏ Authorization for Medication completely filled out, stamped and signed by physician, AND signed by parent/guardian.
- ❏ Copy filed with front office and original given to School Nurse.
- ❏ Medications received in original containers with all identifying labels intact (i.e. student name, medication name, instructions).
- ❏ Medication placed in medication lock box or given to School Nurse / Date: _____/ Time: _____

## SCHOOL NURSE ONLY:

- ❏ Additional follow-up done / Date: _____

Notes:

For questions, please contact: Keegan Roehr, District Nurse, desk phone: 510-601-4747 ext. *169, cell: 510-504-9904, or email: keegan.roehr@emeryusd.org