

# San Dieguito Union High School District

## Authorization for Medication Administration

Section §49423 of the California Education Code allows students to take medication prescribed by a physician during the school day, to be assisted by designated school personnel with the medication, or to carry and self-administer certain medication when authorized in writing by the student's parent/guardian AND physician.

Student Information							
<b>Student Name:</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
	Last                      First                      Initial	Male	Female	Date of Birth	School ID#		
<b>Current School:</b>	_____						Grade: _____

Parent /Guardian Authorization		Please see page 2 for procedure for prescribed and non-prescribed medication
<p>In accordance with Education Code §49423 Sections (a), (b, 1, 2 &amp; 3) and (c) EC §49423.1 Sections (a), (b 1, 2 &amp; 3) and (c)) and EC §49407, I, the undersigned parent/guardian of the above-named minor student, hereby authorize:</p> <p>_____ Designated school district personnel to assist my child with medication administration, monitoring, and testing according to the physician's instructions and approval below.</p> <p>_____ My child to carry and self-administer ___ an auto-injector epinephrine pen or ___ an asthma inhaler according to the physician's instructions and approval below.</p> <p>In accordance with California Education Code §49407, I hereby RELEASE, DISCHARGE, and HOLD HARMLESS the San Dieguito Union High School District, its Board of Trustees, officers, employees and agents from all liability, including injury, death, adverse reactions, or other damages which may arise from the self-administration or assisting with administration of medication according to the authorization and instructions of the undersigned parent/guardian and physician described herein.</p> <p>I agree to provide the medications indicated below in original prescription containers which are labeled with the name of my child, the prescribing physician, the medication, and dosage. I further authorize the school nurse or designated school personnel to consult with the prescribing physician should any questions arise with regard to the medication California Education Code § 49480. <b>I understand that continuous medication requires annual authorization to the school's health office.</b></p>		
Print Parent/Guardian Name	Parent/Guardian Signature	Date
Current Address	Home Telephone	Work Telephone
City	Zip Code	Cell Phone

Physician Authorization		This section to be completed by prescribing physician ONLY		
Name of Medication	Method of Administration	Dosage	Route	Approximate Time of Day
#1: _____	_____	_____	_____	_____
#2: _____	_____	_____	_____	_____
Discontinue medication on: _____				
Instructions for staff assistance: _____				
Storage and other precautions: _____				
<p>_____</p> <p style="font-size: small;">Initials</p>	<p>I authorize my patient to carry and self-administer ___ an auto-injector epinephrine pen ___ an asthma inhaler according to my instructions and approval here stated. I confirm that I have instructed the student in the procedures, dosages, and time schedule by which the medication is to be taken and the student is competent in self-administering the medication. (Education Code §49423 Sections (a), (b, 1, 2 &amp; 3) and (c) EC §49423.1 Sections (a), (b 1, 2 &amp; 3) and (c))</p>			
<b>Prescription Date:</b> _____				
Print Name of Physician	M.D.	Medical License Number	Telephone Number	
Physician's Signature	Date	FAX Number		

**San Dieguito Union High School District**  
**Authorization for Medication Administration**

The procedure for medication by **prescription** and/or **nonprescription** medication listed on this form will be expedited as follows:

1. Only medication prescribed by the student’s physician as being necessary to be taken by the student in the manner listed on this form should be brought to school. **Form must be complete and include required parent and prescribing physician signatures.**
2. Medication brought to school to be administered to the student according to the provisions listed on this form should be in its **original prescription container** or for nonprescription medication in its **original manufacturers container**, clearly marked; with the student’s name, the prescribing physician, the medication; route, dosage, purpose and, pharmacy. (Parent may want to ask the physician for a prescription for a duplicate supply; one for home and one for school).
3. **All medications will be kept in a secure place.** Any special instructions for storage or security measures of any medication should be written by the prescribing physician and delivered to school health office, so that such instructions can be followed.
4. **Parent/Guardian or adult student** (18 yrs or older) shall deliver the medication **and** the completed form to the school health office.
5. **Parent/Guardian or adult student** (18 yrs or older) shall **pick up remaining medication during the last week of school in June.**

If continuance of medication is necessary,  
a new Authorization for Administration of Medication form  
**must be completed for each school year.**

<i>Should you have any questions, please refer to the Health Office of your student’s school site:</i>					
<b>Middle School</b>	<b>Phone #</b>	<b>Extension</b>	<b>High School</b>	<b>Phone #</b>	<b>Extension</b>
<b>CV</b>	858-481-8221	3014	<b>CCA</b>	858-350-0253	4011
<b>DNO</b>	760-944-1892	6631	<b>LCC</b>	760-436-6136	6024
<b>EW</b>	858-755-1558	4414	<b>SDA</b>	760-753-1121	5021
<b>OC</b>	760-753-6241	3378	<b>TP</b>	858-755-0125	2235