Calaveras Unified School District

P.O. Box 788
San Andreas, CA 95249

Authorization for Administration of Medication During School Hours

THIS FORM MUST BE COMPLETED WITH M.D./DENTIST AND PARENT/GUARDIAN SIGNATURES BEFORE ANY MEDICATION CAN BE ADMINISTERED AT SCHOOL.

The California Education Code section 49423 permits the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to be functional at school and participate in the educational program.

- Medication must be in the container in which it was purchased with the pharmacy label attached, and must be prescribed to the student to whom it will be administered. No medication (including over-the-counter medication) will be given at school without a current authorized health care provider prescription.
- Parent/guardian is responsible to ensure that the medication supply is delivered to school by an individual legally authorized to be in possession of the medication.
- Parent/guardian is responsible to provide all necessary supplies and equipment.
- Parent/guardian may terminate this consent for administration of medication at any time.
- The renewal of this medication order is needed whenever the prescription changes and at the beginning of each school year.
- Please refer to Board Policy 5141.21 for additional information.

STUDENT:_____ DATE OF BIRTH:_____ GRADE:_____

PHYSICIAN AUTHORIZATION (all blanks must be completed by a physician):

Name of Medication:		**Method of administration:**
Dosage (mg.):		**Time(s) to be taken:**
Start Date:		**End Date:**
Diagnosis / Justification:		
Precaution – Possible reactions:		

California Code of Regulations §605 states that a student with an existing medical condition that requires frequent monitoring, testing or treatment may be allowed to self administer this service (example may be for diabetes, asthma, anaphylactic reaction). Please check box below if applicable:

☐ **Please check this box if in the authorized health care provider's opinion, the student is competent to safely carry and self-administer the medication according to the conditions in the provider's written statement.**

My signature below provides authorization for the above written order. I understand that the medication will be given in accordance with state laws and regulations by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

Authorized Healthcare Provider Name (please print):		**Address:**
Authorized Healthcare Provider's Signature:	**Date:**	**Telephone Number:**

I the undersigned, the parent/guardian of the above named pupil, request that the school nurse or other designated school personnel assist my student with the above named medication in accordance with state laws and regulations. I will: 1. Provide the necessary medication, supplies, and equipment; 2) notify the school nurse if there are any changes to this order. I give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Parent/Guardian Signature _____ Date _____ Phone Number _____

Address _____