AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS

Valid *only* for the current school year or as designated in the Individual Education Program (IEP) or in the 504 Plan.

Exception: California Education Code 49423.5, specialized services, i.e., EpiPen, nebulizer, glucagon, insulin, diabetes care, etc., may require additional forms and instructions signed by parent or legal guardian and physician. Request *Specialized Services* forms from school.

PARENT OR LEGAL GUARDIAN

1. Parent or Legal Guardian Section

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of physician. Please refer to Legal References Governing the Administration of Medication in Schools on the reverse side of this form.

I request that designated unlicensed, trained school staff or licensed nurse assist my child in taking this prescribed medication (including prescribed over-the-counter medication). I understand that my child may not be assisted with medication at school until all requirements are met. I hereby give consent for a school nurse (or designee) to communicate with my child's prescriber and to counsel school personnel as needed with regard to my child's health. I agree to, and do hereby hold the District and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this medication. I agree to comply with district rules related to administering medication at school.

Name of Child ____________ ❑ M ❑ F Sex ____________ Birth Date ____________ Student Identification Number ____________

Name of School ____________ Grade ____________ Teacher/Room Number ____________

List all medications routinely taken outside of school hours: ____________

I will immediately notify the school if there are any changes in medications my child is taking at school.

Signature of Parent or Legal Guardian ____________ Date ____________ Home/Mobile Telephone ____________ Work Telephone ____________

PHYSICIAN

2. Physician Section

The child named above is under my care. It is necessary for him or her to receive the following prescribed medication during school hours.

Diagnosis for which medication is prescribed ____________

Name of medication (one medication per form) ____________

Dosage (Be specific, i.e., milligrams, etc.) ____________

Time of day to be give ____________ Frequency and Indication if "as needed" ____________

If "as needed" describe indications and sequence orders ____________

Method of administration				
	ORAL	❑ Liquid	❑ Tablet	❑ Inhaler
	DROPS	❑ Eye, ❑ R ❑ L	❑ Ear, ❑ R ❑ L	❑ Nostril, ❑ R ❑ L
	OTHER	❑ Topical,	❑ other ____________	

Precautions or side effects ____________

Storage and handling

- ❑ Routine handling, medication in locked storage and administered by authorized school personnel
- ❑ On-site 72 hour disaster supply only
- ❑ It is *Medical Necessity* for child *to carry* prescription for asthma, anaphylactic shock or diabetes, and indicate:
  - ❑ Designated school personnel to administer
  - ❑ Child trained to self-administer

Additional special instructions ____________

Signature of Physician ____________ Date ____________

Name of Physician (please print) ____________ License Number ____________ Office telephone ____________

Stamp physician name/address below:

Legal References: California Ed Code sections 49423 - 49423.5 and Department of Education, "Program Advisory on Medication Administration, May 2005," updated June 2012

White – School District | Canary – Parent or Legal Guardian | Pink – Physician or Licensed Health Care Provider

SFA 5010, Rev. 3/18/2014