AUBURN UNION SCHOOL DISTRICT
255 EPPERLE LANE
AUBURN, CA 95603
PHONE 530.885.7242 FAX 885.5170

ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Student Name:		Date of Birth:
School:	Grade:	School Year:

PARENT REQUEST
I (we), the undersigned, the parent(s)/guardians of the above named pupil, request the following medication be administered to my (our) child in accordance with the California Education Code 49423. I will: 1. Provide all medication, supplies, and equipment. 2. Notify the district nurse if there is a change in the pupil's health status or attending physician. 3. Notify the school nurse immediately and provide a new consent for any changes in the doctor's orders 4. I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN MEDICATION IT MUST BE ON HIS/HER PERSON IN ORDER TO ATTEND A FIELD TRIP. I authorize the district nurse to communicate with the Authorized Health Care provider when necessary in regards to this specific medication and medical condition.
Parent./Guardian Signature_____ **Date**_____

PHYSICIAN INSTRUCTIONS *(to be completed by health care provider)*	
1. MEDICATION	**Dose/Route/Frequency:**
Indication for medication:	**Is medication a controlled substance? ☐ Y ☐ N**
Special instructions/precautions/side effects:	
2. MEDICATION	**Dose/Route/Frequency:**
Indication for medication:	**Is medication a controlled substance? ☐ Y ☐ N**
Special instructions/precautions/side effects:	
3. MEDICATION	**Dose/Route/Frequency:**
Indication for medication:	**Is medication a controlled substance? ☐ Y ☐ N**
Special instructions/precautions/side effects:	

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ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL (CONTINUED)

HEALTH CARE PROVIDER AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL	
My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance with California state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the District Nurse. This authorization is for a maximum of one (1) year. If changes are indicated, I will provide new written authorization. (May be faxed)	
Physician Signature:	**Date:**
Physician Name:	
Address:	
Telephone:	

SELF ADMINISTRATION AUTHORIZATION/APPROVAL for emergency medication use only	
If any of the above medication is a rescue inhaler or auto-injectable epinephrine that needs to be carried and self-administered by the student, **both the physician, parent/guardian and school nurse must agree, check and sign here** (*District Nurse has final approval for self-administering and/or carrying medication by student at school*)**:**	
Prescriber's authorization for self administration: ☐ Y ☐ N	***Signature/date***
Parent/Guardian authorization for self administration: ☐ Y ☐ N	***Signature/date***
District Nurse authorization for self administration: ☐ Y ☐ N	***Signature/date***

Principal Signature:_____ **Date:**_____

District Nurse Signature: _____ **Date:** _____

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ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Dear Parent/Guardian,

To request medication administration at school, PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. If you have any questions, please contact Jenny Serrano, District Nurse (jserrano@auburn.k12.ca.us)

RESPONSIBILITY OF THE PARENT/GUARDIAN

- **Medication WILL NOT be given until this form is completed and on file in the school health office.**
- ***Students are not permitted to carry any medications, including over-the-counter, on a school campus.* However, a physician, parent/guardian and school nurse may authorize a student to carry his/her prescribed emergency medication (ONLY auto-injectable epinephrine, inhaled asthma rescue medication, or insulin), if necessary, with appropriate documentation.**
- **Parents/guardians may pick up unused medications from the school office during and at the close of the school year. Medication remaining after the last day will be discarded.**

RESPONSIBILITY OF THE PHYSICIAN AND PARENT/GUARDIAN

- **Any medication taken in school (BOTH PRESCRIBED AND OVER THE COUNTER) must be authorized by a parent/guardian AND a health care provider. No medication will be accepted by school personnel without receipt of completed and appropriate medication forms.**
- **Medication must be brought in the original container, both from the pharmacy or over the counter.**
- **If medication is given on an as-needed basis, specify the exact conditions or symptoms when medication is to be taken and the time at which it may be given again.**
- **Unless otherwise specified, medication order is valid for the entire school year.**
- **A new form is needed for all changes in medication, dose or time.**
- **ALL MEDICATION ORDERS MUST BE RENEWED ANNUALLY.**

RESPONSIBILITY OF SCHOOL PERSONNEL

- **Designated school personnel will assume responsibility for placing medications in a locked cabinet.**
- **If the District Nurse is not available to give medication, another trained staff member may be assigned to do so.**
- **District Nurse or designated staff will assist and observe the student in taking medication according to the physician's instructions. The date and time each medication is given will be recorded on the Medication Record form by the staff member assisting the student in taking medication.**
- **The school district and its employees are not responsible for the results of this medication, should any undue reaction occur.**
- **District Nurse/staff members may not administer any medication at times other than those specified on the authorized form.**
- **Expired and discontinued medication not picked up by the last day of school will be destroyed.**

BASIC LEGAL PROVISION *– California Education Code §49423*

Notwithstanding the provision of §49423, any student who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by school personnel if the school district has received: (1) A written statement from such physician detailing the method, amount and time schedules by which such medication is to be taken; and (2) A written statement from the parent or guardian of the student indicating the desire for the school district to assist the student in the matters set forth in the physician's statement.

******PLEASE COMPLETE ATTACHED FORM*****