AUTHORIZATION FOR PRESCRIBED AND OVER THE COUNTER MEDICATION

TULARE COUNTY OFFICE OF EDUCATION

SCHOOL SITE: _____ **FAX #:** _____

Name of Student	Date of Birth	Grade	School Year

Education Code 49423 authorizes that any pupil who is required to take medication during the regular school day, medication prescribed for him/her by a physician, may be assisted by the Credentialed School Nurse or other designated personnel if the school district receives (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/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.

- If your physician would like your child to carry either an asthma inhaler or emergency medication (auto-injectable epinephrine, i.e. Epi-pen), Part III (located on the BACK of this form) MUST be completed by the doctor, parent and child.
- The parent or adult representative designated by the parent must bring all prescribed medications to school in its prescription-labeled container.
- Over-the-counter medications must be brought in an unopened new container.
- All medications will be maintained in the Health Office with the exception of medications designated in Part III, as prescribed by the physician.
- Parent/guardian may pick up unused medications at the close of the school year. Medication remaining after the last day of school will be properly discarded.

PHYSICIAN AUTHORIZATION

(ONE MEDICATION PER FORM)

I. PRESCRIBED MEDICATION REQUIRED TO BE ADMINSITERED DURING SCHOOL HOURS (Completed by Physician ONLY)

Name of Medication:	Health condition for which medication is prescribed:	
Dosage:	Time(s) to be taken:	
Route of administration:	Potential adverse reactions:	
If an asthma relief inhaler is ordered for school and the student has NO response to the first dose, then the dose may be repeated in an EMERGENCY in the school setting. **Please check one of the following:** _____ I give consent _____I do NOT give consent _____ N/A		
Name of Physician (Print name or Stamp)	Physician Phone #:	Physician Fax #:
Physician Signature:	Date:	

II. THIS SECTION IS TO BE COMPLETED BY PARENT / GUARDIAN (Section I and II MUST be COMPLETED)

I give permission for my child to receive the above medication at school according to the district board policy and administrative regulations, and agree to release, indemnify and hold harmless _____ its board member(s), officers, agents & employees from lawsuits, claims, demands, actions or expenses that may arise against them from administering medication as set forth in accordance with the provision of part I above.

- I agree to allow communication and the exchange of pertinent medical information between medical providers and the Credentialed School Nurse involved with my child's medical care.
- I understand that I may terminate consent for such administration of medication at any time, in writing.
- NO MEDICATION WILL BE ADMINISTERED WITHOUT THE REQUIRED SIGNATURES.
- This form MUST be renewed at the BEGINNING of EACH SCHOOL YEAR or WHENEVER there is a CHANGE in MEDICATION or INSTRUCTIONS.

Signature of Parent/Guardian: _____ Relationship: _____ Date: _____

(Self-Administered medication consent form is on BACK)

AUTHORIZATION AND PROTOCOL FOR SELF-ADMINISTERED MEDICATION

TULARE COUNTY OFFICE OF EDUCATION

(PAGE 1 AND 2 MUST BE COMPLETED FOR SELF-ADMINISTERED MEDICATION)

SCHOOL SITE: _____ **FAX #:** _____

Name of Student	Date of Birth	Grade	School Year

In order for your child to carry a self-administered emergency medication on their person, the following must be understood and agreed upon by the student and parents:

- The student may utilize the prescribed self-administered medication as needed and directed by their physician.
- The physician's signature indicates the student has been instructed on the proper use of the prescribed medication.
- The medication must be properly labeled with the student's name.
- Both the Authorization for Prescribed Medication form and this Protocol must be signed by the parent/guardian and placed on file at the school prior to your child carrying a self-administered medication on their person.

Inhaler: **NO DIRECT MONITORING** will be conducted by the school staff. The student is responsible for self-administration of the inhaler. If the student continues to have difficulty breathing, they should report to the school staff and go to the health office and the appropriate school staff will notify the parents.

Self-administered emergency epinephrine: NO DIRECT MONITORING will be conducted by the school staff. The student is responsible for notifying school staff in the event they had the need to self-administer the emergency medication.
It is the parents/guardians responsibility to immediately notify the school if their child's health status changes, or when a change in Physician and/or medication occurs. Changes in procedure must be received in writing from the physician authorizing treatment.

The district is NOT responsible for any risk involved with improper handling of this medication including: overuse, improper administration, breakage, theft, loss, sharing, playing with or careless storage of the medication.
Re-evaluation of the present protocol may be needed if the student is found to display behavior that increases the safety risks of them or the students on campus.

III. **PERMISSION TO CARRY AND SELF-ADMINISTER ASTHMA MEDICATION AND AUTO-INJECTABLE EPINEPHRINE (i.e., Epi-Pen)**

TO BE COMPLETED BY THE PHYSICIAN: The above-named student has been instructed in the proper use of their asthma inhaler/emergency medication. The child's well-being is in jeopardy unless this medication is carried on their person. Therefore, I request that they be permitted to carry the asthma inhaler/emergency medication at school. The child is capable of self-administering the medication, understands the purpose, appropriate method, and frequency of use of the asthma inhaler/emergency medication.

PHYSICIAN (Print name):_____**SIGNATURE:** _____ **DATE:**_____

TO BE COMPLETED BY THE PARENT/GUARDIAN: I permit my child to carry the above-listed asthma inhaler/emergency medication as ordered by their physician. I also specifically release the school districts and all school personnel from any and all civil liability if my child suffers an adverse reaction as a result of self-administering medication during school hours. If parent does not provide the Health Office with a back-up or second inhaler and the student should need medication, the school/district will contact Emergency Services.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN (Print name): _____

TO BE COMPLETED BY THE STUDENT: I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician. I understand that using my medication in a manner other then as prescribed by my doctor can result in disciplinary action taken against me by my School/District.

STUDENT (Print name): _____ **Signature:**_____ **Date:**_____

Please return the fully completed forms to your child's school health office signed by the physician, parent/guardian, and student. Medication forms MUST be renewed at the beginning of each school year or whenever there is a change in medication of instructions.

NO MEDICATION WILL BE ALLOWED OR ADMINSITERED WITHOUT THE REQURIED SIGNATURES