

# Medication at School Form

To be renewed at the beginning of each school year and when changes in medication or authorized health care provider occur.

Parents must provide a Medication Order for prescriptions & over the counter medications.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First

Student ID#: \_\_\_\_\_ School: DAILEY CHARTER SCHOOL Grade: \_\_\_\_\_ Room#: \_\_\_\_\_

California Education Code, Section 49423 defines requirements for administration of medication "... any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which medication is to be taken, and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement."

## TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Diagnosis or Reason for Medication during the school day: \_\_\_\_\_

Name of Medication	Dose	Route	Time(s) to be Given
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Possible side effects or other serious considerations regarding medication(s): \_\_\_\_\_

**FOR AUTO-INJECTOR EPINEPHRINE (EpiPen):**

Student is allergic to: \_\_\_\_\_

Student may carry EpiPen and self-administer  Yes  No (If yes, check statement below)

**FOR ASTHMA INHALERS:**

Student may carry asthma inhaler and self-administer  Yes  No (If yes, check statement below)

Does student need the prescribed medication \_\_\_\_\_ minutes before physical activity or sports?  Yes  No

I have instructed the student in the proper method to use his/her  asthma inhaler and/or  EpiPen and in my opinion the student is competent to safely self-administer the medication at school.

Health Care Provider Signature \_\_\_\_\_ Date: \_\_\_\_\_

Health Care Provider Name / Address (Please Print) \_\_\_\_\_ Phone: \_\_\_\_\_

**PARENT REQUEST AND AUTHORIZATION:**

I request that the school nurse or designated school personnel assist my child with medication as ordered by the health care provider. I give permission for the school personnel to communicate with the health care provider on matters related to this medication. I will notify school personnel of any changes in medication, health status, or authorized health care provider and will provide a new medication order form. I understand I may submit a written statement to withdraw my consent for administration of medication at school at any time.

I understand that the school must receive the medication in a container with a pharmacy label that indicates name of student, health care provider's name, medication, dose, route, and time to administer (over-the-counter medication must be in the original container). I understand that the medication must be delivered to the school by the parent, guardian, or adult designee. I understand that medication (including over-the-counter) can only be administered to my child at school if the school has received ALL of the following: a.) Current California-authorized health care provider order, b.) Parent / guardian signature, and c.) Properly labeled medication.

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_