



**PARENT CONSENT AND HEALTHCARE PROVIDER AUTHORIZATION
FOR MANAGEMENT OF MEDICATIONS AT SCHOOL AND SCHOOL SPONSORED EVENTS**

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| Student _____ Birthdate _____ School _____ | | |
| HEALTHCARE PROVIDER: Please check all of the boxes that apply. | | |
| FOR DIAGNOSIS OF ASTHMA/ALLERGIES ONLY Medication: _____ Spacer Required <input type="checkbox"/> No <input type="checkbox"/> Yes Administration times (fill in times for only those that apply): <input type="checkbox"/> Daily at _____ <input type="checkbox"/> PRN for s/s Asthma/Allergy episode <input type="checkbox"/> Other _____ Medication administered via: <input type="checkbox"/> Inhaler <input type="checkbox"/> Nebulizer <input type="checkbox"/> Other _____ Medication Dose: <input type="checkbox"/> 2 puffs every 4 hours <input type="checkbox"/> Other _____ | FOR ALL OTHER CONDITIONS Medication: _____ Diagnosis for which medication is prescribed: Dosage (Be specific, i.e. milligrams, etc.) Time of day to be given Frequency if "as needed" Method of Administration: <input type="checkbox"/> Oral <input type="checkbox"/> Liquid <input type="checkbox"/> Tablet <input type="checkbox"/> Drops – Eye R / L <input type="checkbox"/> Drops – Ear R / L <input type="checkbox"/> Drops – Nostril R / L Precautions, reactions, or side effects: _____ | |
| MEDICATION STORAGE AND HANDLING <input type="checkbox"/> Routine handling, medications in locked storage and administered by authorized school personnel <input type="checkbox"/> Refrigeration If medically necessary: <input type="checkbox"/> Child trained to carry, school personnel to administer <input type="checkbox"/> Child trained to carry and self-administer (medicate) | For Allergic Reaction: If the following symptoms occur: <input type="checkbox"/> Choking <input type="checkbox"/> Hives <input type="checkbox"/> Skin Rash <input type="checkbox"/> Swelling (eyes/lips) <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Other: _____ Administer <input type="checkbox"/> EpiPen <input type="checkbox"/> Other _____ <input type="checkbox"/> Transport student to nearest emergency room | |
| Additional Orders: _____ | | |
| AUTHORIZED HEALTH CARE PROVIDER AUTHORIZATION My signature below provides authorization for the above written orders. I understand that administration of medication to students will be implemented in accordance with state law governing school health services. I understand that administration of medication to students may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. If changes are indicated, I will provide new written authorization (may be faxed). <input type="checkbox"/> I have instructed _____ in the proper way to use his/her medication. It is my professional opinion that he/she can carry and use an inhaler and/or Epi-pen by him/herself. | | |
| _____ Authorized Health Care Provider Signature | | Please Stamp Physician Name and Address Here |
| _____ Date | | |
| Phone Number _____ | FAX _____ | |
| PARENT OR GUARDIAN CONSENT FOR MANAGEMENT OF MEDICATIONS AT SCHOOL AND SCHOOL SPONSORED EVENTS I the undersigned parent/guardian of the above named student, request that the above administration of medication in school be administered to my child in accordance with state laws and regulations. I will: | | |
| 1. Provide the necessary supplies and equipment. 2. Notify the school nurse if there is any change in pupil health status or attending physician. 3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders. I authorize the school nurse to communicate with the physician when necessary | | |
| _____ Parent/Guardian signature | _____ Print Name | _____ Date |
| Self-administration | | |
| I request that my child be allowed to carry and self-administer his/her medications, inhaler and/or Epi-pen. I agree to and do hereby hold the District and its officers, agents, employees and/or volunteers harmless for any and all claims, demands, causes of actions, liability, damages, expenses, or loss of any sort, including bodily injury or death, because of or arising out of actions of omissions with respect to the administration of the medication(s). | | |
| _____ Parent/Guardian signature | _____ Print Name | _____ Date |

Please return form to the school office, Fax to the school office:

Note: All medicine 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, and the name of Physician or Licensed Health Care Provider. **A PARENT OR AN ADULT MUST DELIVER MEDICATION TO THE SCHOOL.**

NOTICE OF PROVISIONS
Legal References Governing the Administration of Medication in Schools
In accordance with the California Education Code Sections 49423, 49423.5, 49480
And California Administrative Code, Title 5, 18170

California Education Code, Section 49423
Administration of prescribed medication for pupil

Notwithstanding the provisions of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the 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 or guardian of the pupil indicating the desire that the school district assist the pupil in matters set forth in the physician's statement.

California Education Code, Section 49423.5
Specialized physical health care services

a) Notwithstanding the provisions of Section 49422, any individual with exceptional needs who requires specialized physical services, during the regular school day, may be assisted by the following individuals:

- 1) Qualified persons who possess an appropriate credential issued pursuant to Section 44267, or hold a valid certificate of public health nursing issued by the State Department of Health Services or
- 2) Qualified designated school personnel trained in the administration of specialized physical health care provided they perform such services under the supervision of a school nurse, public nurse or licensed physician and surgeon.

b) Specialized health care or other services that require medically related training shall be provided pursuant to the procedures prescribed by Section 49423.

c) Persons providing specialized physical health care services shall also demonstrate competence in basic cardiopulmonary resuscitation and shall be knowledgeable of the emergency medical resources available in the community in which the services are performed,

d) "Specialized physical health care services" as used in the section include catheterization, gavage feeding, suctioning, or other services that require medically related training.

e) Regulations necessary to implement the provisions of this section shall be developed jointly by the State Department of Health Services, and adopted by the State Board of Education.

California Education Code, Section 49480
Continuing medication regimen for non-episodic condition; required notice to school employees

The parent or legal guardian of any public school pupil on a continuing medication regimen for a non-episodic condition shall inform the school nurse or other designated certificated school employee of the medication being taken, the current dosage, and the name of the supervising physician. With the consent of the parent or legal guardian of the pupil, the school nurse may communicate with the physician and may counsel with the school personnel regarding the possible effects of the drug on the child's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects, omission, or overdose. The superintendent of each school district shall be responsible for informing parents of all pupils of the requirements of this section.

California Administrative Code Title 5, 18170
The agency shall follow these provisions pertaining to medication

- 1) An assigned staff member shall administer medications prescribed by a physician for a child provided written parental consent has been given.
- 2) Record of medication dosages to the child and date and time medication is administered shall be maintained by the facility.
- 3) Centrally stored medicines shall be kept in a safe and locked place that is not accessible to persons other than employees responsible for health supervision. Each container shall carry the name of the medication, the name of the person for whom prescribed, the name of the prescribing physician and the physician's instructions. All centrally stored medications shall be labeled and maintained in compliance with State and Federal laws. Each person's medication shall be stored in its originally received container. **NO MEDICATIONS SHALL BE TRANSFERRED BETWEEN CONTAINERS.** The agency shall be responsible for assuring that a record of centrally stored prescription medications for each person in care includes; the name of the person for whom prescribed, the drug name, strength and quantity, the date filled, the prescription number and name of issuing pharmacy.
- 4) All medications shall be centrally stored in an area which is totally inaccessible to children.

GUSD 20170817

Please return form to the school office, Fax to the school office:

Mary Buren Fax: (805) 343-2512

Kermit McKenzie: (805) 343-6931