IUSD HEALTH SERVICES PHONE: 949-936-7520 FAX: 949-936-7539

PARENT/GUARDIAN & HEALTH CARE PROVIDER REQUEST FOR MEDICATION ADMINISTRATION

Student Name _____ Birthdate _____ School & Year _____ Grade _____

Telephone – Home _____ Telephone - Work _____ Telephone - Cell _____ Teacher _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION PRESCRIPTION AND NON-PRESCRIPTION

California Education Code Section 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instruction. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified school nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Parent/Guardian Signature: _____ Date: _____

Emergency medicine such as an EpiPen or inhaler may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept in health office for emergency use.

All medication must be in the student's original, labeled pharmacy container. The directions for administration on the school container must be in English. You may request additional containers from your pharmacist, one for school and one for home, if needed. (Non-prescription medication must also be in the original container.)

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for medication (diagnosis): _____

Medication: _____ Dose: _____ Route: _____ Time: _____

If PRN: Amount of time between doses: _____ Maximum number of doses per school day: _____

Possible medication reactions: _____

Instructions for emergency care: _____

Date of request: _____ Date to discontinue medication: _____

The above medication cannot be scheduled for other than during school hours and non-medical school personnel may assist with the administration under the supervision of a qualified school nurse.

_____
Authorized Health Care Provider Signature Date

_____
Address

_____
Telephone Number Fax

Office Stamp

Regarding EpiPens/Inhalers: It is my professional opinion that this student should be permitted to carry/self-administer this emergency EpiPen or inhaler. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials: _____

SCHOOL USE ONLY:
Reviewed by: _____ Date: _____

THIS REQUEST IS VALID ONLY FOR THE CURRENT SCHOOL YEAR