



10.7 BUSD MEDICATION AUTHORIZATION

RETURN COMPLETED FORM TO SCHOOL WITH GUARDIAN AND HEALTH CARE PROVIDER SIGNATURES

Student's Name: _____ **Date of Birth:** _____

School: _____ **Grade:** ___ **Room/Teacher:** _____

Parent/Guardian Home Phone # _____ **Parent/Guardian Cell Phone #** _____

PARENT/GUARDIAN AUTHORIZATION:

CA EDUCATION CODE AUTHORIZATION EDUCATION CODE 49423

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 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.

I authorize BUSD to administer medication to the student in accordance with the authorized health care provider's written statement. I authorize BUSD to communicate directly with the student's authorized health care provider, as may be necessary, regarding the authorized health care provider's written statement. I understand that I may terminate consent for the administration of medication to the student by submitting a written statement rescinding my consent to the student's school at any time.

Parent/Guardian Signature Date

If Applicable: I consent to the student self-administering emergency or otherwise necessary medications. I authorize BUSD to communicate directly with the student's authorized health care provider, as may be necessary, regarding the authorized health care provider's written statement. I agree to hold BUSD, its officers, or employees, harmless from all liability or claims that might arise if the student suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature Date

NO MEDICATION (PRESCRIBED OR OVER THE COUNTER) WILL BE ADMINISTERED WITHOUT PARENT AND MEDICAL PROVIDER SIGNATURES. REFER TO RESPONSIBILITIES ON PAGE 2. Please return this form to your child's school office each new school year.



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AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication:

Medication: _____ Dose: _____ Route: _____

Time: _____

If PRN: Amount of time between doses _____ Maximum number of doses _____ Specific symptoms that necessitate medication: _____

Possible medication

reactions: _____

Instructions for emergency care:

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (print clearly): _____

Telephone _____

Provider NPI # _____

Date of Request: _____

Date to Discontinue Medication: _____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in and demonstrates an understanding of proper usage. Health Care Provider Initials _____

Parents are requested to give medication at home and on a schedule other than during school hours. If it is necessary that a prescription or over-the-counter medication be given during school hours, the following regulations will be followed.

- Medication must be brought to school by an adult in the original container with the appropriate pharmacy label or package instructions intact. (When you get prescriptions filled, you can ask the pharmacist to divide the medication into two containers so you will have one for school and one for home use.) Refills need to be brought to the office by an adult and the new container left with the office.
Parent/guardian must sign the opposite side of this form granting designated school personnel permission to administer medication and acknowledging that you have read and agree to the terms of this form.
Physician must complete Page 1 of this form for all medications. For long-term medication, a consent form must be completed by the parent/guardian and physician for



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- If there is a change in the medication, method of administering the medication, frequency or medication dosage, the physician and parent must complete a new form. At the end of the school year, all medications must be picked up by the parent/guardian on the last day of school, or it will be destroyed per safety regulations.
- With written parent and physician approval, students may be allowed to carry medication. Students carrying medication must use the medication appropriately and not allow other students access to the medication.
- Students with written permission to carry medication from their physician and parent may be subject to disciplinary action under Education Code section 48900 if the student uses inhaled asthma medication or auto-injectable epinephrine in a manner inconsistent with the law.
- The District cannot accept or act on any parent/guardian generated changes or modifications to the medication administration directions unless the District receives such changes in writing from the authorized health care provider.

FOR SCHOOL USE ONLY		Amount Received (Count with Parent or Another Adult)	Signature of Person Bringing Medication	Signature of School Employee Receiving Medication
Date	Medication			

This request is valid for a maximum of one year.