

ESCONDIDO UNION SCHOOL DISTRICT
MEDICATION AUTHORIZATION AND PLAN

This form is valid for the 20____ - 20____ school year School _____

All students receiving prescription or non-prescription (over-the-counter) medication at school require a Medication Authorization and Plan. This Authorization serves as an Individual Health Plan (IHP) for Special Education students or a Section 504 Accommodation Plan as applicable, for all other students. Prescription and non-prescription medications are permitted at school **only** when a completed Medication Authorization and Plan is on file. If any of the conditions of this Authorization change, a new form must be completed and signed by the parent AND authorized health-care-provider.

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

Student's Name _____ Birthdate: _____ Grade: _____

Parent/Legal Guardian: _____ Phone Numbers: H (____) _____

Address: _____ W (____) _____

As parent/legal guardian of the above-named student, I request that a designated member of the school staff make available the following listed medication(s) to my child as prescribed on this Authorization, and in accordance with California law.

I also authorize, as needed, the exchange of information related to my child's health between the school nurse (or designee) and the authorized health-care-provider listed below. I will comply with the procedures listed on the back of this form related to dispensing medication at school.

Parent/Guardian Signature _____ Date _____

TO BE COMPLETED BY AUTHORIZED HEALTH-CARE-PROVIDER:

I hereby authorize a designated member of the school staff to assist in the administration of the following medication to the above student as follows:

Medication	Dose	Route	Time	Diagnosis/Conditions
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Side effects that may be experienced (even if given as prescribed) include: _____

The above student has been instructed by me in the proper use of the above listed medication(s). In my professional opinion, the student **MAY / MAY NOT** carry and administer this medication him/herself. (THIS APPLIES ONLY TO THE USE OF INHALERS FOR ASTHMA AND/OR MEDICATION FOR USE IN EMERGENCY SITUATIONS OF ANAPHYLACTIC REACTIONS)

Printed Name of Physician MD/DO/DDS/DPM/NP/PA CA License #

Address Telephone #

Physician's Signature Date

PROCEDURES FOR ADMINISTERING MEDICATION TO STUDENTS AT SCHOOL

The procedures for administering prescription and/or non-prescription (over-the-counter) medication to students during the school day will be executed under the following conditions:

1. Only medication to be administered to the student at school as prescribed and authorized by the student's physician in the manner stated on this form may be brought to school. (Written parent permission is also required)
2. Such medication shall be administered and taken directly by the student in accordance with the instructions by the physician listed on this form.
3. Medication **MAY NOT** be brought to school by students. All medication must be transported to school by a parent/guardian or another adult authorized in writing by the parent/guardian to deliver the medication.
4. Medication brought to school must be brought in the original prescription or manufacturer's container with the following clearly labeled: (Parent/guardian may want to ask the pharmacist about the possibility of special "school packaging" - a separate container labeled just for the school-time dose) the label must match the Medication Authorization and Plan.
 - the name of the student
 - the name of the prescribing provider
 - the pharmacy dispensing the medication or the manufacturer
 - the strength of the medication and the amount to be given (dose)
 - the method of administration (oral, inhaled, topical, etc.)
 - the specific time or specific situation(s) the medication is given
5. Parent/guardian must count the pills and sign the Medication Log when medication(s) are brought to and from school.
6. A completed and signed Medication Authorization and Plan form must accompany the medication provided to the school. Fax copies are permitted until the original signed copy can be delivered to the school. The Medication Authorization and Plan and medication label must have the same medication name, dose, route and time.
7. All medication will be kept in a secure place. Any special instructions for storage or security measures must be written by the physician and given to school personnel.
8. Students carrying and administering their own medication must have the physician circle consent on the front of this form and must have the principal's prior approval. The school office staff and nurse must be informed that the student carries medication/inhaler on campus.
9. A new Medication Authorization and Plan form must be completed for any change in dose, time, or method. Medication Authorizations will be valid for the current school year only or until a discontinuing date listed by the prescribing physician. If the medication is discontinued a Doctor's note must be provided to the school.
10. Medications must be picked up by the parent/guardian within one day of the end of the school year or they will be discarded.
11. For special education students with a current IEP, this Authorization serves as an Individual Health Plan (IHP) added to the special education file.
- 12. *Students are allowed to use sunscreen during the school day without a physician's note or prescription.***