AUTHORIZATION FOR PRESCRIBED AND OVER THE COUNTER MEDICATION ADMINISTRATION

This form must be completed before any medication (prescription or over the counter) can be given, or taken, at school.
Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.

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

PHYSICIAN USE ONLY: Form and prescription label must match exactly

1. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

☐ Oral ☐ Nasal ☐ Topical
Route: ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** _____ **Stop Date:** _____

☐ **If DAILY ~ Time(s) to be given:** _____

☐ **If AS NEEDED (prn) - Frequency:** ☐**Every 3 to 4hrs.,** ☐ **Every 4 to 6hrs** ☐**Every 6hrs**☐**.Before exercise** ☐ **Other**_____
☐ ***Self-administered – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
(**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

_____

2. MEDICATION: _____ **Dose:** _____ **Reason/Diagnosis:** _____

☐ Oral ☐ Nasal ☐ Topical
Route: ☐ Inhale ☐ Injection ☐ Other ____ **Med Start Date:** _____ **Stop Date:** _____

☐ **If DAILY ~ Time(s) to be given:** _____

☐ **If AS NEEDED (prn) -Frequency:** ☐**Every 3 to 4hrs.,** ☐ **Every 4 to 6hrs** ☐**Every 6hrs**☐**.Before exercise** ☐ **Other**_____
☐ ***Self-administered – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence.**
(**Not** recommended in elementary school)

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

_____

Physician Signature: _____ **Date:** _____

Physician Name: _____

Address: _____ **Phone:** _____

City: _____ **Zip:** _____

I/we hereby request that the Staff of the Central School District assist with giving medication (s) to my/our child _____ (students name) as stated in the above physicians instructions. Release of Liability and Agreement to Indemnify and Hold School District Harmless (must be completed)

I/we hereby expressly release the staff of the Central School District harmless and agree to indemnify the Central School District and it's governing Board members, officers, employees, agents, representatives, independent contractors and insurers from all claims and liability (including civil liability) for personal injuries, adverse reactions, or property damage that may be the result of the District permitting the school district to assist in giving my child's medication. This release and indemnification agreement shall remain in effect until the written notice to terminate the agreement is received and acknowledge in writing by the school. I/we understand and agree that if I/we terminate this agreement, the school will no longer assist in giving medication to my child. I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions by checking box in the order above for self-carry).

I give permission for the appropriate school staff to contact the prescribing physician with questions pertaining to this medication(s) only.

Parent Signature _____ **Date**_____ **Parent contact phone**_____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.

California Education Code section 49423 provides that 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 school 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 the matters set forth in the physician's statement.

Parent Permission

For Medication Self Carry

(must be ordered by physician on page 1)

Student Name: **Date of Birth:**

- **For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTORS SELF-administered only**: I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication. I understand the school nurse will also determine my child's ability to self-carry his/her medication. * I also give permission to contact the physician for consultation and exchange of information as needed. I/we hereby expressly release, hold harmless, and agree to indemnify and defend the Central School District and its Governing Board members, officers, employees, agents, representatives, independent contractors and insurers (collectively referred to as the "District") from all claims and liability for any personal injuries, death, or property damage that may be incurred by any other student or person as a result of permitting _____(student's name) to carry his/her mediation on his/her person at school.
- California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

Signature of Parent or Guardian: _____ **Date:** _____ **Phone Number:** _____

School Nurse Use Only Student Contract – Asthma Inhalers Only

OBSERVED Yes	No	
___	___	Doctor's order has requested that student be allowed to carry his/her own medication(s) at school or on a field trip
___	___	**Parent and student have met with school nurse** and correct use of medication(s) is demonstrated by student
___	___	Proper timing for medication(s) use is indicated by order and is able to be verbalized by student.
___	___	Student is able to verbalize rule of not sharing medication(s) with other students.
___	___	Medication(s) to be kept with student at all times.
___	___	Agrees to come directly to the Health Office, with a buddy, or immediately notify teacher if the student continues to have difficulty after using the medication.
___	___	Provides second container of medication(s) to be kept in the Health Office in case student' is lost or stolen

Student Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____

Central School District Office
8316 Red Oak Ave.
Rancho Cucamonga, CA 91730
909-989-8541 Fax 909-941-1732

School Fax Numbers

Bear Gulch Elementary	909-484-2730	Dona Merced Elementary	909-980-0066
Central Elementary	909-484-2740	Ruth Musser Middle School	909-980-3042
Coyote Canyon Elementar7	909-980-1596	Valle Vista Elementary	909-981-9718
Cucamonga Middle School	909-483-3201		