Julian Union High School District
PO Box 417 - 1656 Highway 78 - Julian, CA 92036-0417 - 760-765-3208 - 765-2926 fax

Dear Parent or Guardian:

Some students need to take medication during the school day. Others need to carry emergency or life-sustaining medication or equipment on their person (i.e., inhaler, insulin, Epi-Pen, blood glucose testing equipment). If this applies to your son/daughter, please have your physician complete the attached "Authorization for Medication Administration" form below. **This form needs to be completed on an annual basis.**

School staff are not permitted to dispense over-the-counter (OTC) medications without a signed Authorization for Medication Administration.

Parent/guardian must check student's medications into the office; medications need to be in their original container with the label intact. OTC medications must be checked into the office in a factory sealed container.

If your son/daughter is administering his/her own blood glucose tests, you will be requested to complete an additional form. You may obtain this form from the high school office.

Even if the school personnel are not dispensing medication to your son/daughter, it is critical that the District ensure the proper handling and disposal of medical supplies and equipment. Medications that are not picked up by the last day of school will be destroyed.

If you have any questions about these procedures, please phone the District office.

Sincerely,

Dr. Michael O. Dodson

Dr. Michael O. Dodson
Superintendent/Principal

Julian Union High School District
AUTHORIZATION FOR MEDICATION ADMINISTRATION
Education Code 49423

I, the undersigned, as legal parent/guardian of _____
Student's Name

_____ attending Julian Union High School District requests that the following medicine(s):
Birth Date School

_____

be made available to my child at the times prescribed _____

I understand that only personnel authorized by the school principal will assist my child in taking the medicine(s) as directed by my physician.

I will provide the medicine(s) *in the prescription container(s)*, which is labeled with the name of my child, the prescribing physician's name, and amount of medication prescribed.

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician

Prescription and nonprescription medications are not permitted to be taken at school without a written statement from the physician *and* a written statement from the parent indicating desire that the district assist the student as set forth in the physician's statement below.

This form valid for school year 2023-2024

I recognize that this is a service or accommodation that the school is not legally required to perform. I agree to save and hold the district, its officers, employees, or agents, harmless from all liability, suits or claims of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

_____ _____
Signature Date

_____
Home Address

_____ _____
Work Phone Home Phone

THIS PORTION TO BE COMPLETED BY A PHYSICIAN LICENSED IN THE STATE OF CALIFORNIA

1. **Name of Medication Method of Administration Dosage Approximate Time of Day

A. _____

B. _____

2. Discontinue "Medication A" on _____ and "Medication B" on _____
Date Date

3. Type of assistance for administering medication (observe, measure, etc.):

_____

4. Precautions for administration or storage of medication:

_____

5. Do you wish to have school personnel contact you at intervals to discuss this medication?

___ Yes ___ No Please indicate: Person(s) _____, Intervals _____
Teacher, Nurse Weekly, Quarterly, etc.

****If medication is an inhaler, EpiPen, or insulin, and may be carried on person, check here___.**
****If glucose testing equipment will be carried on person, check here ___.**

_____, M.D. _____ _____
Printed Name of Physician Medical License Number Phone Number

_____ _____
Signature of Physician Date