Ripon
UNIFIED SCHOOL DISTRICT

Authorization for Medication Administration During School Hours

In compliance with Education Code Section 49423, no medication will be accepted or administered at school without meeting the following requirements. The procedure for administration of medication by **prescription** and/or **nonprescription/Over The Counter (OTC)** medication listed on this form will be expedited as follows:

1. Only medication prescribed by the student's physician as being necessary to be taken by the student in the manner listed on this form should be brought to school. **Form must be complete and include required parent and prescribing physician signatures.**
2. Medication brought to the school to be administered to the student according to the provisions listed on this form should be in its **original prescription container** or for nonprescription/OTC medication, in its **original manufacturers container**, clearly marked with the student's name, the prescribing physician, and the medication order; medication name, route, dosage, time/frequency, and pharmacy. (Parent may want to ask physician for a prescription for a duplicate supply; one for home and one for school).
3. Medications that contain narcotics (some pain medications, some cough medications) **will not** be administered at school.
4. **All medications will be kept in a secure place in the school office**. Any special instructions for storage or security measures of any medication should be written by the prescribing physician and delivered to the school office, so that such instructions can be followed.
5. **Parent/Guardian or adult student (18 years or older)** shall deliver the medication and the completed form to the school office.
6. **Parent/Guardian or adult student (18 years or older)** shall pick up remaining medication during the last week of school. The school site is not responsible for medication left in the office during the summer.

If continuance of medication is necessary,

a new Authorization for Medication Administration During School Hours form

Section §49423 of the California Education Code allows students to take medications prescribed by a physician during the school day, to be assisted by designated school personnel with the medication, or to carry and self-administer certain medication when authorized in writing by the student's parent/guardian AND physician.

STUDENT INFORMATION

Student Name:_____ □Male □Female Date of Birth:_____

Current Address: _____ Current School:_____ Grade:_____

Parent / Guardian Authorization PLEASE SEE PAGE 1 FOR PRESCRIBED AND NON-PRESCRIBED MEDICATION REQUIREMENTS

In accordance with Education Code §49423 Sections (a), (b, 1, 2 &3) and (c) EC §49423.1 Sections (a), (b, 1, 2 & 3) and (c) and EC §49407, I, the undersigned parent / guardian of the above named minor student hereby authorize:

_____ Initials School nurse or designated school personnel to **assist** my child with medication administration, monitoring, and testing according to the physician's instructions and approval below.

_____ Initials My child to **carry and self administer:** ☐ an auto injector epinephrine pen, ☐ an asthma inhaler, or ☐ insulin and blood sugar monitoring/supplies according to the physicians instructions and approval below.

In accordance with California Education Code §49407, I hereby RELEASE, DISCHARGE, and HOLD HARMLESS the Ripon Unified School District, officers, employees and agents from all liability, including injury death, adverse reactions, or other damages which may arise from the self administration or assisting with administration of medication according to the authorization and instructions of the undersigned parent/guardian and physician described herein.

I agree to provide the medications indicated below in original prescription containers, or original manufacturers containers, which are labeled with the name of the child, the prescribing physician, the medication, and dosage instructions. I further authorize the school nurse or designated school personnel to consult with the prescribing physician should any questions arise with regard to the medication California Education Code §49480. **I understand that continuous medication requires annual authorization to the school's office.**

_____ Print Parent / Guardian Name

_____ Parent / Guardian Signature

_____ Current Address

_____ Cell Phone

_____ Work Phone

Physician Authorization THIS SECTION TO BE COMPLETED BY PRESCRIBING PHYSCIAN ONLY

Condition for which medication(s) are being taken: _____

	Name of Medication	Dosage	Frequency	Route	Time of Day
#1:					
#2:					

Instructions for care of student after medication administration, i.e., rest, home, hospital, doctor's office, return to class:

_____

Possible reactions after administration of medication: _____

Storage and other precautions: _____

Start Date: Immediate / Other Date:_____ Stop Date: End of Year / Other Date: _____

_____ Initials I authorize my patient to **carry and self administer:** ☐ an auto injector epinephrine pen ☐ an asthma inhaler and/or ☐insulin and blood sugar monitoring/supplies according to my instructions and approval here stated. **I confirm that I have instructed the student in the procedures, dosages, and time schedule by which the medication is to be taken and the student is competent in self-administering the medication**. (Education Code §49423 sections (a), (b, 1,2 & 3) and (c) EC §49423.1 Sections (a), (b, 1, 2 &3) and (c))

_____ Print Name of Physician

_____ Physician's Address

_____ Telephone Number

_____ Physician's Signature

_____ Date

_____ Fax Number

School Nurse Signature: _____ Date: _____

Site Principal Signature: _____ Date: _____