EAST SIDE UNION HIGH SCHOOL DISTRICT
HEALTH SERVICES

SCHOOL MEDICATION ADMINISTRATION: PHYSICIAN AND PARENT/GUARDIAN AUTHORIZATION

This form must be completed by a California licensed health care provider and the student's parent/guardian. This permit must be renewed at the beginning of each school year and whenever there is a change in the student's medication dosage or medication administration plan. Students who must carry and self-administer emergency medication on campus must have an "Authorization to Carry and Self- Administer Emergency Medication on Campus" form along with this authorization on file in the school office.

Student Name:_____Grade:_____School: _____

DOB:_____Parent's daytime phone:_____Home Phone:_____

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TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Name of Medication: / Strength:	
Required Dose: / Route:	
Reason for giving medication:	Time to be given at school: daily ☐ as needed ☐ For daily, use set time or set event such as "before PE" or "at lunch"
If medication to be given as needed describe indications: include allergen(s)/ signs & symptoms for epinephrine/allergy medications	
How soon can it be repeated?	Medication administered until: (date) or end of school year ☐
List significant side effects:	
Additional information/instructions for school personnel:	

It is necessary for this medication to be taken during the school day at the time(s) indicated above. Medication may be administered by designated school personnel.

Health Care Provider Signature:_____Date: _____

Health Care Provider Name (stamp or print):_____License No. _____

Address:_____Phone: _____

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TO BE COMPLETED BY PARENT/GUARDIAN

I understand and agree to the following parent/guardian responsibilities regarding medication administration.

- To provide written authorization to administer medication from my child's authorized health care provider.
- To assume responsibility for delivery of my child's medication, in its original and properly labeled container, to the school office (medication not labeled or in their original container shall not be administered).
- To inform school personnel of any changes in my child's medication plan and provide updated physician/parent authorization as needed.
- To provide school personnel with pills split for accurate dose if needed, appropriate measuring tools necessary for accurate dose measurement (e.g.: tsp for liquids), and all supplies and equipment needed to manage condition (e.g. diabetes)
- To pick up all unused medication at the end of the school year.

I authorize school personnel to administer the above medication to my child as ordered by the licensed health care provider listed above. I give permission for the authorized district representative to communicate directly with my child's health care provider, as may be necessary regarding the health care provider's written statement or any other questions about the medication. I understand I may terminate this consent at any time by informing the school district in writing.

Parent/Guardian Signature:_____Date: _____