Encinitas Union School District
101 S. Rancho Santa Fe Rd., Encinitas, CA 92024

AUTHORIZATION FOR MEDICATION ADMINISTRATION

(Education Code Section 49423)

I, the undersigned, as legal parent/guardian of _____
Student Name Teacher Grade

_____ attending _____ request that the following medication(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 medication as directed by my physician. I authorize school personnel to contact my physician as needed.

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

I understand that 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.

I agree to save and hold the district, its officers, employees or agents, harmless from all liability suits or claims, or whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

THIS FORM VALID ONLY FOR SCHOOL YEAR

20 _____ to 20 _____

_____
Signature of Parent/Guardian Date

_____
Home Address

_____ _____
Work Telephone Home Telephone

Physician Statement

This portion to be completed by a physician licensed in the State of California. (If P.R.N. describe symptoms)

Name of Medication	Method of Administration	Dosage	Approximate Time of Day
#1_____	_____	_____	_____
#2 _____	_____	_____	_____

2. Discontinue Medication #1 on _____ and Medication #2 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 to discuss this medication?
Intervals _____
Yes ☐ No ☐ (If yes, please indicate one of the following): Daily, Weekly, Quarterly, etc.

_____ _____ _____
Printed Name of Physician Medical License Number Telephone Number

_____ _____
Signature of Physician Date

-OVER-

1. Only medication prescribed by the pupil's physician as being necessary to be taken by the pupil in the manner listed on this form should be brought to school. (Written parent permission also required.)

2. Such medication should be taken by the pupil in accordance with instructions from the physician as listed on this form.

3. Medication brought to school to be given to the principal according to the provisions listed on this form should be in its prescription containers which are clearly marked with the name of the pupil; the name of the prescribing physician; the druggist who dispensed the medication or the manufacturer; and the amount of medication to be taken at specified times or in specific situations, etc. (Parents may want to ask the physician for a duplicate supply, one for home and one for school.)

4. All medication will be kept in a secure place. Any special instructions for storage or security measures of any medication should be written by the physician and given to school personnel so that such instructions can be followed.

5. Parent or responsible adult shall deliver the medication and the completed form to the school health office.

6. A new medication authorization must be renewed for each school year if a continuance of medication is necessary.