San Dieguito Union High School District
Authorization for Medication Administration

Section 49423 of the California Education Code allows students to take medication 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: ____ **Birth Date:** __________________________________

School: ____ **Grade:** ______________________________________

Parent/Guardian Authorization

In accordance with California Education Code §49423, I, the undersigned parent/guardian of the above-named minor student, hereby authorize:

____ Designated school district personnel to assist my child with medication administration, monitoring, and testing according to the physician's instructions and approval below.

____ My child to carry and self-administer an auto-injector epinephrine pen according to the physician's instructions and approval below.

____ My child to carry and self-administer an asthma inhaler according to the physician's instructions and approval below.

In accordance with §49407 & §49423, I hereby RELEASE, DISCHARGE, and HOLD HARMLESS the San Dieguito Union High School District, its Board of Trustees, 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 prescription containers which are labeled with the name of my child, the prescribing physician, the medication, and dosage. 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.

____ ____

Print Parent/Guardian Name **Parent/Guardian Signature**

____ ____

Home Address **Date**

( ) ( ) ( )

Work Telephone **Home Telephone** **Cell Phone**

Physician Authorization

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

Discontinue medication on: ____

Instructions for staff assistance: ____

Storage and other precautions: ____

________ (Initials) I authorize my patient to carry and self-administer ______an auto-injector epinephrine pen _____asthma inhaler according to my instructions and approval below. 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. **Prescription Date:** ____________________________________

M.D. #

Print Name of Physician **Medical License Number**

( ) ( )

Physician's Signature **Telephone Number** **FAX Number**