SANGER UNIFIED SCHOOL DISTRICT

MEDICATION AT SCHOOL - SCHOOL YEAR: 20___ - 20 ____

Student's Name:_____ Birthdate: _____ Grade: _____

California Education Code, Section 49423 defines certain requirements for administration of medication **"... any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which medication is to be taken, and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement."** SUSD Administrative Regulation (AR) 5141.21(a) will only allow students to administer their own medications (inhaled asthma medication, auto-injectable epinephrine or diabetic insulin) with written permission from their physician and parent as stated above and after having received instruction and shown understanding of proper administration procedures.

Additionally, SUSD AR No. 5141.21(a) indicates that school personnel are **prohibited** from administering any over-the-counter or medications including aspirins, vitamins, antihistamines, etc. unless the medication is accompanied with **written permission from both the parent/guardian and physician.** Any medication to be administered at school **must be** clearly labeled, sent to school in a container from the pharmacy, or its' original sealed container (for over the counter medications) **and will be kept in the school office unless otherwise directed as noted above. A new Medication at School form is required each school year.**

If you require additional information regarding the above, please contact the school nurse at: (phone)_____(fax)_____

School Nurse:_____ School: _____Date _____

PARENT/GUARDIAN REQUEST We, the undersigned, who are the parents/guardian of_____request that the school nurse or designated school personnel assist our child in the matter set forth by this physician's statement. In the event of an untoward or subsequent reaction, it is understood that the school personnel will in no way be held responsible for carrying out this request. I will notify the school of any changes in my child's health status or plans for participation in extracurricular activities. I authorize the exchange of information between my child's Physician, School Nurse and/or site Administrator regarding this medication request.

Parent/Guardian Signature: Date

Medication(s) is (are) needed at school for the following reason(s): _____

NAME OF MEDICATION(S)	DOSAGE	TIME(S) TO BE GIVEN	ROUTE
1.			
2.			
3.			

Time limit on medication # _ : if other than current school year: (i.e., 10 days, field trip only): _____

PE/Activity instructions: Self-pace - Yes / No (circle one) **Other:** _____

Self Administration: Student has been instructed and may carry / self-administer inhaler**: YES / NO** (circle one).

Other Instructions: _____

Signature below indicates authorization of Medication Orders as noted above:

Physician's Name (please print or type) _____Phone:_____

Physician's Signature_____ Date: _____

Reviewed by School Nurse: _____ Signature: _____ Date: _____