SAN LUIS COASTAL
UNIFIED SCHOOL DISTRICT

MEDICATION CONSENT FORM

Parents are requested to give medication at home and on a schedule other than during school hours. When it is necessary for prescription or over-the-counter medication to be given during school hours, written parent and health care provider authorization is required. This authorization is provided by the completion of both pages of Medication Consent Form. The following procedures are required:

1. **Permission is granted to the school nurse to contact the health care provider if necessary.**
2. **All unused medications shall be picked up by the parent no later than 5 working days following the last day of the school year, or it will be destroyed per safety regulations.**
3. Parents **shall** sign the "parent/guardian authorization" below, which grants designated school personnel permission to administer **prescription or over-the-counter** medication.
4. Health care provider shall complete and sign the health care provider authorization (on the reverse side) for **prescription or over-the-counter** medication.
5. Prescription or over-the-counter medication **shall** be brought to the school by an adult in the **original container** with the appropriate label. Medication in baggies, envelopes, or other containers will not be accepted. (Upon request, pharmacists will divide the medication into two containers, one for school use and one for home use).
6. Instructions on the health care provider authorization form shall match those on the medication label. Parent may terminate the consent to administer medication via a written note only.
7. The school staff will not accept medication delivered by the student. The parent or a designated adult shall deliver the medication to the school site.
8. **A new consent form shall be completed each time there is a change in medication strength, dosage, or time. Parent may terminate the consent to administer medication via a written note only.**
9. For long-term medication, the consent form **MUST** be completed by the parent and health care provider each **new school year.**
10. A student may carry and self-administer medication **only** when the health care provider initials the appropriate section of the consent form. This privilege may be revoked if the student is known to misuse his medication and thus be of harm to himself or others.
11. Students attending summer school are covered by consent forms completed during the current school year. The parent is responsible for providing the medication and a **copy** of the authorization form as part of summer school registration.

PARENT/GUARDIAN AUTHORIZATION

I am the parent/guardian of _____
(Print Name of Student)

I request the San Luis Coastal Unified School District (SLCUSD) to assist my child in taking medication as stated in the health care provider authorization (reverse side of this document).

I agree to indemnify and hold harmless the SLCUSD, its offers, agents, and employees, for any injury, illness, or death which might occur as a result of assisting with the administration of the medication in accordance with the health care provider's direction. I understand that medication may only be administered by a licensed health care professional, trained unlicensed staff member, parent, or parent designee according to state laws and regulations.

Parent Phone number _____

Print Name of Parent/Guardian	**Signature of Parent/Guardian**	**Date**

*Administration of Prescribed Medication for Pupils (Education Code) E.E. 49423 . . . 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 received (1) a written statement from such physician detailing the method, amount, and time schedules by which such 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 matters set forth in the physician's statement.

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HEALTH CARE PROVIDER AUTHORIZATION

Name of child (print):_____ Birth Date:_____

Name of medication (one medication per form):_____

Reason for medication (diagnosis):_____

Strength (mg, etc.):_____ Dosage (amount):_____

Time of day or frequency to be given at school:_____

For "as needed" (prn) medications, describe indications (symptoms) when to be used:_____

_____

Method of administration (oral, topical, eye drops, etc.) and directions:_____

_____

Possible side effects of medication:_____

_____

SELF-MEDICATION

Student may carry and administer his own medication **ONLY** if ALL the items below are initialed by the physician/dentist:

- ☐ Medication is needed by student for immediate emergency condition (i.e. diabetes, asthma, anaphylaxis, migraines)
- ☐ It appears that the student is physically, mentally, and behaviorally capable to assume responsibility.
- ☐ Student has successfully demonstrated self-medication procedure to health care provider.

Additional comments/directions:_____

_____

_____ _____ _____
Health Care Provider (Print) Signature Date

_____ _____
Telephone Number Fax Number

_____
Address

School Site: _____ School Year: _____ School fax: _____