San Dieguito Union High School District
Authorization for Administration of Medication

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 Name: _____ ☐ ☐ _____ _____
Last First Initial Male Female Date of Birth M/D/Y School ID#

Current School: _____ Grade: _____

Parent /Guardian Authorization

Please see page 2 for procedure for prescribed and non-prescribed medication

In accordance with Education Code §49423 Sections (a), (b, 1, 2 & 3) and (c) EC §49423.1 Sections (a), (b 1, 2 & 3) and (c)) and EC §49407, I, the undersigned parent/guardian of the above-named minor student, **hereby authoriz**e:

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

_____ ***Parent's Initials*** **My child to carry and self-administe**r ☐ an auto-injector epinephrine pen or ☐ an asthma inhaler according to the physician's instructions and approval below.

In accordance with California Education Code §49407, 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 original 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 California Education Code § 49480. **I understand that continuous medication requires annual authorization to the school's health office.**

_____ _____ _____
Print Parent/Guardian Name Telephone: Home ☐ Work ☐ Cell Phone

_____
Current Address City Zip Code

_____ _____ _____
Email Address **Parent/Guardian Signature** **Date**

Physician Authorization

This section to be completed by prescribing physician ONLY

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

Discontinue medication on: _____

Instructions for staff assistance: _____

Storage and other precautions: _____

_____ ***MD Initials*** I authorize my patient to carry and self-administer ☐ an auto-injector epinephrine pen ☐ an asthma inhaler according to my instructions and approval here stated. 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. (Education Code §49423 Sections (a), (b, 1, 2 & 3) and (c) EC §49423.1 Sections (a), (b 1, 2 & 3) and (c))

Prescription Date: _____

_____**M.D.** _____ _____
Print Name of Physician Telephone Number FAX Number

_____ _____ _____
Medical License Number **Physician's Signature** **Date**

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The procedure for medication by **prescription** and/or **nonprescription** medication listed on this form will be expedited as follows:

1. Only medication prescribed by the student's physician as being necessary to be taken by the student in the manner listed on this form should be brought to school. **Form must be complete and include required parent and prescribing physician signatures.**

2. Medication brought to school to be administered to the student according to the provisions listed on this form should be in its **original prescription container** or for nonprescription medication in its **original manufacturers container,** clearly marked; with the student's name, the prescribing physician, the medication; route, dosage, purpose and, pharmacy. (Parent may want to ask the physician for a prescription for a duplicate supply; one for home and one for school).

3. **All medications will be kept in a secure place**. Any special instructions for storage or security measures of any medication should be written by the prescribing physician and delivered to school health office, so that such instructions can be followed.

4. **Parent/Guardian** or **adult student** (18 yrs or older) shall deliver the medication **and** the completed form to the school health office.

5. **Parent/Guardian or adult student** (18 yrs or older) shall **pick up remaining medication during the last week of school in June**.

If continuance of medication is necessary,
a new Authorization for Administration of Medication form
must be completed for each school year.

Should you have any questions, please refer to the Health Office of your student's school site:					
Middle School	**Phone #**	**Extension**	**High School**	**Phone #**	**Extension**
CV	858-481-8221	3014	**CCA**	858-350-0253	4011
DNO	760-944-1892	6631	**LCC**	760-436-6136	6024
EW	858-755-1558	4414	**SDA**	760-753-1121	5021
OC	760-753-6241	3378	**TP**	858-755-0125	2235
PT	858-509-1000				

Additional Pertinent Information: