Vista Unified School District

AUTHORIZATION FOR MEDICATION ADMINISTRATION

(Education Code Section 49423)

This portion to be completed by pupil's school personnel.

The back side of this form must be signed by parent before returning to school.

Name of Pupil ____ Birth Date ____________
Last, First, Middle Month/Day/Year

______________________ ________ _______________________ ___________ ______
School Teacher Room Grade

This form is valid only for school year **2020** to **2021**.

Location of medication: Locked in the school health office, unless authorized to self-administer

Type of container: Original pharmacy container

Person(s) authorized to assist pupil (health tech, secretary, self if authorized below) __________________________

Who is to bring medication to school? (Name of adult) ____

How often will medication be brought to school? (Daily, weekly, etc.) As needed when medication is finished

- PHYSICIAN'S STATEMENT -

1. Medication   Method of Administration   Dosage   Time or Interval   (Symptoms for PRN)

#1 ____

#2 ____

2. Reason for administration ____
3. Special instructions/side effects ____
4. I certify this student is competent to carry and safely self-administer this medication. ________________________
Signature of Provider
5. Precautions for administration or storage of this medication ____
6. Indications for referral for medical evaluation ____

___________________________, M.D. ___________________________________ ______________________
Printed name of Prescribing Provider   Provider Address   Provider Telephone Number

____ ______________________ ______________________
Signature of Prescribing Provider   Provider License Number   Date

Form # 5023.3 11/94 (Rev 6/1/20-LM)

VISTA UNIFIED SCHOOL DISTRICT **AUTHORIZATION FOR MEDICATION ADMINISTRATION**

(Education Code Section 49423)

Any pupil who is required to take, during the regular school day, medication prescribed for him by a health care provider, may be assisted by the school nurse or other designated school personnel if the school district receives:

1) A written statement from such health care provider detailing the method, amount, and time schedules by which such medication is to be taken. *See the reverse side of this form.*
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 health care provider's statement. *See authorization statement below.*

This authorization is valid only for the current school year. If any of the conditions in the health care provider's statement change, parent/guardian must notify the school nurse and a new form must be signed by the parent/guardian and the provider. The parent/guardian may submit a written statement rescinding consent for administration of medication at school at any time. Parent/guardian will inform the school nurse of any changes in the student's health status or health care provider.

Only medication prescribed by the pupil's authorized health care provider as being necessary to be taken by the pupil in the manner listed on the provider's statement should be brought to school. Medication should be in original containers which are clearly marked with the name of the pupil, the name of the medication, and the amount of the medication.

This portion to be completed by the parent/guardian.

I request that a school nurse or other district designee administer the medication as directed by the health care provider on the reverse side of this form to my child:

____

Pupil's Name

I recognize the fact that this is a service or accommodation which the school is not legally required to perform. I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

I consent for the school nurse or site administrator to communicate with the authorized health care provider and pharmacist with regard to the provider's written statement for administration of medication at school.

______________________________________ ___________________

Signature of Parent/Guardian *Date*

____

Work Telephone Number/Home Telephone Number

DISTRITO ESCOLAR UNIFICADO DE VISTA AUTORIZACIÓN PARA ADMINISTRAR MEDICAMENTOS

(Sección 49423 del Código de Educación)

Cualquier alumno(a) que necesite tomar, durante el día escolar, un medicamento recetado por un médico para él/ella, puede ser asistido(a) por una enfermera escolar u otro empleado escolar designado si el distrito escolar recibe:

1) Una declaración escrita de dicho medico detallando el método, cantidad y horario a seguir para administrar dicho medicamento. *Refiérase al la parte de atrás de este formulario.*

2) Una declaración escrita de parte de los padres o tutores del alumno indicando que desean que el distrito escolar asista al alumno(a) a llevar a cabo lo indicado en la declaración médica. *Refiérase a la declaración de autorización a continuación.*

Esta autorización únicamente es válida durante el presente año escolar. Si algunas de las condiciones contenidas en la Declaración Médica cambian, un formulario nuevo debe ser firmado por los padres/tutores y el medico.

Unicamente los medicamentos que el medico le prescribió al alumno que se necesitan administrar al alumno de la manera enumerada en la Declaración Médica deben traerse a la escuela. El medicamento debe estar dentro de un envase que esté identifcado con el nombre del alumno, nombre del doctor que prescribe el medicamento, y la cantidad del medicamento.

Esta parte debe ser llenada por los padres/tutores.

Yo solicito que una enfermera escolar u otro representante del distrito, le administer a mi hijo(a) el medicamento según las instrucciones del medico, contenidas en la parte de atrás de esta hoja:

____

Nombre del alumno

Yo reconozco el hecho de que este es un servicio o favor que la escuela no tiene que realizar legalmente. Yo estoy de acuerdo con mantener al distrito, sus oficiales, empleados o agentes, libres de cualquier responsabilidad, demandas o quejas de cualquier naturaleza o especie, que puedan suscitarse como resultado de la administración del medicamento conforme a esta solicitud.

____ _______ ______________________________

Firma de los padres/tutores *Fecha* *Número de teléfono*