**MANZANITA ELEMENTARY SCHOOL DISTRICT**

**AUTHORIZATION FOR MEDICATION TO BE GIVEN AT SCHOOL**

**School Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Pupil Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_\_ School Site: Manzanita Elementary School

School Phone Number: (530) 846-5594\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School FAX: (530) 846-4084\_\_\_\_\_\_\_

Dear Parent/Guardian:

Administration of Prescribed Medication during regular school hours - Education Code 49423 Notwithstanding the provisions of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him 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 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. (Enacted by Stats. 1976, Ch. 1010.)

**ALL MEDICATIONS WHETHER PRESCRIPTION OR NON-PRESCRIPTION (including Tylenol, cough drops, motion sickness medicine, etc.) REQUIRE DOCTOR AND PARENT/GUARDIAN AUTHORIZATION, AND MUST BE IN THEIR ORIGINAL CONTAINERS AND/OR PRESCRIPTION BOTTLES.**

(1) Medication to be administered\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time of Day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Anticipated reactions to medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Refrigeration required? yes\_\_\_\_\_\_\_\_\_\_ no\_\_\_\_\_\_\_\_\_\_\_

(2) Medication to be administered\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time of Day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Anticipated reactions to medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Refrigeration required? yes\_\_\_\_\_\_\_\_\_\_\_ no\_\_\_\_\_\_\_\_\_\_\_\_\_

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Physician’s Signature Date**

**The proper use and risk of carrying an INHALER or EPIPEN on the school premises will be the responsibility and liability of the student and parent.**

□ **Physician: Check box if you feel it is medically necessary for the child to carry the above prescribed INHALER or EPIPEN with him/her during school hours.**

Education observations of children on medication will be made when necessary if you desire to speak to someone regarding these observations, please contact the school.

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Physician’s Signature Date**

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**I approve of this authorization for medication to be given to my child by school personnel.**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**

**Phone (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT’S AUTHORIZATION FOR EXCHANGE OF INFORMATION** -

I also give my permission for the exchange of information regarding my child’s medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Name

Between: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and Manzanita Elementary School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Physician Name of School

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Parent/Guardian**

Please return form to School Office: Manzanita Elementary School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BAK 6/14/16**