ENCINITAS UNION SCHOOL DISTRICT **Valid for School Year _____ to _____**

Authorization for Medication Administration

Prescription and Non-Prescription Medications

Section §49423 of the California Education allows students to take medication prescribed by a physician during the school day, to be assisted in administration of the medication by designated school personnel, or to carry and self-administer certain medication when authorized in writing by the student's parent/guardian AND physician.

Student Information

Student Name: _____ ☐ M ☐ F Date of Birth:_____
Last First M.I.

School: _____ Grade: _____ Teacher: _____

Parent/Guardian Authorization

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

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

_____ my child to carry and self-administer ☐ an auto-injector epinephrine pen or ☐ an asthma inhaler according to the physician's instructions and
Initials authorization below.

In accordance with California Education Code §49407, I hereby release, discharge, and hold harmless the Encinitas Union School District, its Board of Trustees, officers, employees, and agents from all liability relative to injury, death, adverse reactions, or other damages that may arise from self-administration or assistance with administration of medication according to the instructions of the undersigned parent/guardian and physician described herein.

I agree to provide the medications indicated below in original prescription containers that are labeled with the name of my child, the prescribing physician, medication name, and dosage. I further authorize the school nurse or designated school personnel to consult with the prescribing physician should any questions arise regarding the medication in accordance with California Education Code §49480. I understand that all medications require annual authorization.

_____ _____ _____
Print Parent/Guardian Name Parent/Guardian Signature Date

_____ _____ _____
Address Home Telephone Work Telephone

_____ _____
City Zip Code Cell Phone

Physician Authorization- This section to be completed by the 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: _____

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

Prescription Date: _____

_____ _____ _____
Print Name of Physician Medical License Number Telephone Number

_____ _____ _____
Physician's Signature Date FAX Number