REACH Leadership STEAM Academy

AUTHORIZATION FOR PRESCRIBED AND OVER-THE-COUNTER MEDICATION ADMINISTRATION AT SCHOOL

Name of Student _____ DOB: _____ Grade: _____ School: REACH LSA

Education code 49423 authorizes that 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 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/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.

- If your physician would like your child to carry either an asthma inhaler or emergency medication (auto-injectable epinephrine,i.e. Epipen), Part III must be completed by the doctor, parent and child.
- The parent or adult representative designated by the parent must bring all prescribed medications to school in its prescription-labeled container.
- Over-the-counter medications must be brought in an unopened container.
- All medications will be maintained in the Health Office with the exception of medications designated in Part III, as prescribed by the physician.
- Parent/guardian may pick up unused medications at the close of the school year. Medication remaining after the last day of school will be properly discarded.

PHYSICIAN AUTHORIZATION
(ONE MEDICATION PER FORM)

I. PRESCRIBED MEDICATION REQUIRED TO BE ADMINISTERED DURING SCHOOL HOURS.
(THIS SECTION IS TO BE COMPLETED BY PHYSICIAN)

_____ Name of medication(s)	_____ Health condition for which medication is prescribed
_____ Time(s) to be taken	_____ Dosage
_____ Route of administration	_____ Precaution-possible untoward reactions
_____ Date to be discontinued	_____ Special Instructions
_____ Name of Physician	_____ Physician's Phone No.
_____ Physician's Signature	_____ Date

II. THIS SECTION IS TO BE COMPLETED BY PARENT/GUARDIAN.

I give permission for my child to receive the above medication at school according to the district board policy and administrative regulations, and agree to release, indemnify and hold harmless *REACH Leadership STEAM Academy,* its board members, officers, agents & employees from lawsuits, claims, demands, actions or expenses that may arise against them for administering medication as set forth in accordance with the provision of part I above.

- I agree to allow communication and the exchange of pertinent medical information between medical providers and the School Health Clerk involved with my child's medical care.
- I understand that I may terminate consent for such administration of medication at any time, in writing.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Relationship:_____ Date: _____

NO MEDICATION WILL BE ADMINISTERED WITH THE REQUIRED SIGNATURES. THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR OR WHENEVER THERE IS A CHANGE IN MEDICATION OR INSTRUCTIONS. PARTS I AND II MUST BE COMPLETED.

REACH Leadership STEAM Academy

PART III: SELF-ADMINISTRATION OF PRESCRIBED MEDICATION

(PAGE 1 AND 2 MUST BE COMPLETED FOR SELF-ADMINISTERED MEDICATION)

❑ ***NEW***	❑ ***CONTINUING MEDICATION***

Pursuant to school board policy, all student medication must be stored in the health office and taken by the student only when a permission form is on file signed by the parent and physician. This practice provides for the safety of all students on campus. Because the medication is taken under supervision, the student is protected from inappropriate use of the medication. If the medication fails to provide relief, further care can be provided by the staff as necessary.

It is recognized that on occasion, a medical condition requires immediate administration of prescribed medication, and the student's well being wellbeing in jeopardy unless the medication is carried on his/her person. In these instances, it is necessary to have this form completed and signed by the physician and parent/legal guardian.

Sincerely,

REACH Health Office

****

(THIS SECTION IS TO BE COMPLETED BY PHYSICIAN)

_____ is under my care for _____
(Student Name) (Diagnosis)

this warrants immediate administration of _____.
The above named student must carry this medication on his/her person. The student has demonstrated knowledge of the correct dosage and administration and is sufficiently responsible to carry out my directions as instructed. In addition, s/he will notify the school health office whenever s/he takes the medication for the purpose of monitoring and record keeping.

Medication is to be used by the above student as follows:

_____ _____
Dose *Frequency*

_____ _____
Start Date *Discontinue Date*

Physician Information:

_____ _____
Physician's Signature *Address*

_____ _____
Telephone *Date*

(THIS SECTION IS TO BE COMPLETED BY PARENT/GUARDIAN)

I, the parent/guardian of _____,
desire REACH Leadership STEAM Academy to comply with the orders of the above physician and will inform the school of any changes from the above diagnosis/prescription. I further agree to hold REACH Leadership STEAM Academy harmless if any injury occurs to my child due to unsupervised use of prescribed medication at school per this request.

_____ _____
Parent/Legal Guardian Signature *Date*

_____ _____
Student Signature *Date*

NO MEDICATION WILL BE ADMINISTERED WITH THE REQUIRED SIGNATURES. THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR OR WHENEVER THERE IS A CHANGE IN MEDICATION OR INSTRUCTIONS. PARTS I AND II MUST BE COMPLETED.