COASTAL ALLERGY CARE
Caring Accessible Excellence

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SCHOOL MEDICATION FORMS

What Parents Need To Know To Have a SCHOOL MEDICATION FORM Completed

- **IF patient has NOT been seen within 6 - 9 months, Schedule an Office Visit so the form(s) can be completed accurately. Especially important for EpiPen, Benadryl and Asthma patients.**
- **Please complete the Form Section "Parent or Legal Guardian" (this is very important).**
- **Schools typically require one form per medication, check with your school.**
- **Attach medication name to the form; which office you will pickup form and your best telephone #.**
- **Form completion may take up to 72 business hours. Please provide your forms early.**
- **We do NOT fax or mail any school medication form.**

AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS

Valid *only* for the current school year or as designated in the Individual Education Program (IEP) for Special Education students.

EXCEPTION: California Education Code 49423.5 - Specialized services, i.e., EpiPen, AnaKit, glucagon, nebulizer, etc., may require additional forms and instructions signed by Parent or Legal Guardian and Physician. Request *specialized services forms* from school.

Please review the **'Notice of Provisions' California Education Code (CEC) Sections 49423, 49423.5, 49480 and California Administrative Code (CAC) Title 5, 18170,** printed on the reverse side of this form.

PARENT OR LEGAL GUARDIAN

Part 1: To be completed by Parent or Legal Guardian

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of Physician.

I request that designated school personnel assist my child in taking this prescribed medication (including prescribed over-the-counter medication). I agree to, and do hereby hold the District and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this medication. I understand that my child may not have nor taken medication at school unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's Physician and counsel school personnel as needed with regard to this medication.

_____ ⊙M ○F _____ _____ _____

Child's Name | Sex | Birthdate | SS# | Student ID#

_____ _____ _____ _____

Name of School | Grade | Teacher | Room Number

List all medications routinely taken *outside* of school hours _____

I have read and understand the 'Notice of Provisions' printed on the reverse side of this form pertaining to **'Authorization For Any Medication Taken During School Hours.'** I will ***immediately*** notify the school if there are any changes in medications my child is taking at school.

_____ X_____ (___)_____ (___)_____ (___)_____

Date | **Signature** Parent or Legal Guardian | Home Telephone | Work Telephone | Cell #/Pager #

PHYSICIAN

Part 2. To be completed by the Physician

The child named above is under my care. It is necessary for him or her to receive the following prescribed medication during school hours.

Diagnosis for which medical is prescribed_____

Name of medication (one medication per form)_____

Dosage (Be specific, i.e., milligrams, etc.)_____

Time of day to be given_____ **Frequency if 'as needed'**_____

If 'as needed' describe indications and sequence orders _____

Method of administration **ORAL** ☐Liquid ☐Tablet ☐Inhaler **DROPS** ☐Eye **R** ☐ **L** ☐ ☐Ear **R** ☐ **L** ☐ ☐Nostril **R** ☐ **L** ☐

OTHER ☐Topical or ☐_____

Precautions or side effects_____

Storage and handling ☐Routine handling, medication in locked storage and administered by authorized school personnel
☐72 hour disaster supply only

If *Medical Necessity* for child *to carry* prescription for asthma, anaphylactic shock or diabetes:
☐Designated school personnel to administer ☐Child trained to self-administer

Additional special instructions_____

_____ X_____

Date | **Signature** Physician

_____

Please print name

_____

Office address

(_____)_____ (_____)_____

Office Telephone | Office FAX

Stamp Physician name/address below.