MEDICATION ASSISTANCE AUTHORIZATION

2016-2017

(Authorization signed/dated by doctor after June 30, 2016)

Student Name:_____ SIS#:_____ D.O.B._____

Address: _____

School:_____Grade:____ Teacher:_____

Parent/Guardian Phone: Home:_____ Work:_____Cell:_____Emergency:_____

IMPORTANT INFORMATION

In accordance with California Education Code Section 49423, and Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990, students who have a Medical Disability for which a physician has prescribed Medication to be taken during the school day, whether of limited or permanent duration, are entitled to seek Assistance from the District in meeting their Medication needs for when the student is under the District's care, custody, or control, including while on field trips, sporting events, and other off-campus District-sponsored activities.

Before Medication Assistance can be provided, even if the student has an Individualized Education Plan ("IEP") or a "504 Plan," this Medication Assistance Authorization form ("Authorization") must be executed by at least one parent/legal guardian **and** the student's duly authorized health care provider. **A new Authorization is required at the beginning of each school year and any time there is a change in Medication directives, such as change in Medication, dosage, timing, or frequency.** The parent/legal guardian must immediately notify the District of any change in Medication directives. Until the District receives an updated Authorization, signed by the parent/legal guardian and health care provider, the District will continue the directives in the existing Authorization unless (a) there is evidence the student's health may be endangered by the continued use of the former Medication directive, or (b) the parent/legal guardian provides a written statement that Medication Assistance is to cease or be suspended until the new Authorization can be provided. In such situations, the parent/legal guardian will need to provide the Medication Assistance to the student at agreed times during the school day in a safe and appropriate manner that does not unduly disrupt the educational environment. **At the end of the school year, all medication must be picked up within 5 days, or it will be destroyed per safety regulations.**

All Medication must be provided to the District by a parent/legal guardian, with the District storing the Medication and dispensing it in compliance with the Medication directive. All medication supplied to the District must be in its original labeled form (i.e., in the original prescription bottle, sealed package, etc.) as received from the physician, pharmacist, or store. Except for personal asthma inhalers and personal epi-pens**, a student may not independently possess Medication during the school day or while on District property.** Due to health and safety concerns, including the potential theft of the Medication or the potential for sharing/use of the Medication by other students who may then suffer unexpected allergic or other negative reactions, there are no exceptions to this requirement. A student personally possessing Medication, or providing Medication to another student, may face discipline.

PARENT/GUARDIAN AUTHORIZATION

I have read, understand, and agree to be bound by the rights and obligations contained in the Important Information section of this Authorization. I request that Medication Assistance be provided to my Student.

The Student understands his/her obligations described in the Important Information section, including the need to ensure he/she complies with the directions for receiving Assistance (i.e., coming to the school or nurse's office each day, at the same time, without need for a District employee to attempt to locate them) and the policy against his/her personal possession or sharing of Medication (except for possession of asthma inhalers and epi-pens). I understand that if the Student fails to meet these obligations that he/she may face discipline and/or this Authorization may be revoked.

Unless required by law, I understand there is no guarantee that Medication Assistance will be performed by a nurse or licensed health care provider, although the District will take reasonable steps to ensure that the District employee providing Assistance has received training that complies with all legal requirements. As a partner with the District in protecting the Student's health and safety, I will work with school staff regarding Medication Assistance issues, including Medication Assistance issues when the Student is expected to be involved in off-campus District-sponsored activities. **I will also timely advise the District of any change in Medication directives. It is my responsibility to obtain a new Authorization form, signed by a licensed health care provider, when there is a change in Medication directives.** I will comply with my responsibilities described above should those Medication directives change**._____(initial of parent/guardian)**

PARENT/GUARDIAN AUTHORIZATION

With respect to the Medication Assistance issues covered by this Authorization, I authorize the District and the health care provider below to discuss the student's medical and/or Medication information, and I authorize the health care provider to provide any additional information to the District as may be necessary to carry out this Authorization.

Date	Signature Parent/Guardian	Printed Name Parent/Guardian

PHYSICIAN AUTHORIZATION

STUDENT MEDICAL DIAGNOSIS: _____

1st Medication Name:	**Reason/Diagnosis:**	**Dosage:**	**Route:**
Duration:(date/week/month/until discontinued)	☐ **Daily** (Indicate interval/Time of Day)	☐ **Emergency Only** (Describe Symptoms/Triggers)	☐ **As Needed** (Describe Symptoms/Triggers)
Student capable of self-administering? ☐Yes ☐No		Student may/should carry medication? ☐Yes ☐No **(applies only to inhalers/epi-pens)	
Must a District employee have special training/experience before providing assistance? ☐Yes ☐No (If yes, describe the training/experience).			
Post Assistance Care/Potential Adverse Reactions/Follow-up/Emergency Care:			

2nd Medication Name:	**Reason/Diagnosis:**	**Dosage:**	**Route:**
Duration:(date/week/month/until discontinued)	☐ **Daily** (Indicate interval/Time of Day)	☐ **Emergency Only** (Describe Symptoms/Triggers)	☐ **As Needed** (Describe Symptoms/Triggers)
Student capable of self-administering? ☐Yes ☐No		Student may/should carry medication? ☐Yes ☐No **(applies only to inhalers/epi-pens)	
Must a District employee have special training/experience before providing assistance? ☐Yes ☐No (If yes, describe the training/experience).			
Post Assistance Care/Potential Adverse Reactions/Follow-up/Emergency Care:			

Additional Remarks/Directions: (If more than two medications are prescribed, or more explanation is needed, physically attach to this Authorization a separate signed sheet noting the additional information)_____

_____

Physician's Name _____ Medical License No. _____

Address _____ Telephone Number _____

Physician s Signature_____ Date _____

**** Signature stamp require from medical office****

This form shall be completed each school year