Durham Unified School District

Dona Hildenbrand, School Nurse

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AUTHORIZATION FOR MEDICATION TO BE GIVEN AT SCHOOL

Pupil Name:_______________ Date of Birth:__________ School Year: ________

Teacher:_______________ Grade Level:________ Site: ☐ DES ☐DIS ☐DHS

Dear Parent/Guardian/Care Provider:

California Educational Code, Section 49423 provides that any pupil required to take medication during regular school days, may be assisted by the school nurse or designated school personnel. **ALL MEDICATIONS** WHETHER PRESCRIPTION OR NON-PRESCRIPTION REQUIRE DOCTOR AND PARENT AUTHORIZATION, AND MUST BE IN THEIR ORIGINAL CONTAINERS/ CURRENT PRESCRIPTION BOTTLES.

(1) Medication to be administered:_______________ Dosage (mg, tsp, etc.):________
Time to be administered:_______________ Duration to be given: ________
Anticipated reactions to medication:_______________

(2) Medication to be administered:_______________ Dosage (mg, tsp, etc.):________
Time to be administered: _______________ Duration to be given:________
Anticipated reactions to medication:_______________

State law allows students with asthma or severe allergic reactions to carry and self administer their prescribed medications if two requirements are met. 1) Physician statement confirms that the student is able to self-administer medication 2) Parent consents for self-administration and by signing below absolves school personnel from civil liability if the self-administering student suffers an adverse reaction

☐ Check box if student may carry asthma medication or Epinephrine auto-injector

☒ _______________ / ________ / _______________ / ________

Physician's Signature Date Physician's Printed Name Telephone/Fax #

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

☒ _______________ / ________ / _______________ / ________

Parent/Guardian Signature Date Home/Cell Phone # Work Phone #

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PARENT'S AUTHORIZATION FOR EXCHANGE OF INFORMATION

I hereby give my permission for the exchange of information regarding my child's medication, between_______________and Durham Unified School District.

Physician's Name

☒ _______________ / ________

Parent/Guardian Signature Date