Palo Alto
Unified School District

# Medication Authorization

## School Hours/Field Trips/Disasters (24-72 Hours)

School _____ School Year _____ Fax _____

Student Name _____ DOB _____

*This form **must be renewed annually**, **and** if there are any changes in treatment or medication during the school year.*

**Physician** -- Complete Medication List Below *Mark* All That Apply

**MEDICATION # 1**

Medication Name: _____ Strength: _____ Required Dose: _____

Reson for giving medication: _____

☐ Tablet/Capsule ☐ Liquid ☐ Injection ☐ Topical ☐ Inhaler ☐ Nebulizer

Time(s) to be given at school: _____ ☐ Daily ☐ PRN If PRN, frequency: _____

If PRN, for what symptoms: _____ Relevant side effects: _____

Medication shall be administered from: _____ to _____ or ☐ Remainder of school year

*Additional Instructions:* _____

**MEDICATION # 2 (If Needed)**

Medication Name: _____ Strength: _____ Required Dose: _____

Reson for giving medication: _____

☐ Tablet/Capsule ☐ Liquid ☐ Injection ☐ Topical ☐ Inhaler ☐ Nebulizer

Time(s) to be given at school: _____ ☐ Daily ☐ PRN If PRN, frequency: _____

If PRN, for what symptoms: _____ Relevant side effects: _____

Medication shall be administered from: _____ to _____ or ☐ Remainder of school year

*Additional Instructions:* _____

My signature below provides authorization for the above orders. All procedures will be implemented in accordance with states laws and regulations. Specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse.

_____ _____

Physician Signature Date

_____ _____

Phone Fax

Clinic Stamp

Health Services
25 Churchill Avenue
Palo Alto, CA 94306
Tel. 650-833-3735 | Fax 650-833-4226



Updated 5/22/2017

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Unified School District

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## School Hours/Field Trips/Disasters (24-72 Hours)

### Parent/Guardian Consent

I request that my child be allowed to take medication at school according to instruction from the above health care provider. I authorize school personnel to assist with this medication for my child as ordered from the above health care provider. I understand trained, non-medical personnel may assist with or administer medication (Ed Code 49423 and 49480).

**I give consent to communication and exchange of information between PAUSD, the health care provider listed above, and the pharmacy listed on the prescription medication above regarding the health care provider's written statement or any other questions about the medication or medication administration.**

**I understand and agree to the following responsibilities regarding medication administration:**

1. This form must be renewed whenever student's prescription changes and at beginning of each school year.
2. Prescription medication must be in a container labeled by the pharmacist or health care provider and will not be expired.
3. Non-prescription medication must be in the original container with the label intact.
4. An adult must bring the medication to the school health office and pick up any outdated or unused medication.
5. Pill splitting must be done by parent/guardian prior to providing medication to school officials.
6. Parents/Guardians provide all materials or necessary equipment (e.g. measuring spoon) for medication administration.
7. Students may not carry and self-administer medication unless authorization has been given by student, parent, and health care provider.
8. Parents will notify the school and provide new consent for any changes to the above authorization.
9. Any modifications or changes to the above authorizations may only be made after written notification is received from the health care provider.
10. I understand that 911 will be called in the event emergency medication is given.

| Parent Signature | Phone | Date |
|---|---|---|

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