

**EUREKA UNION SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT**

5455 Eureka Road
Granite Bay, CA 95746



4-8th ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

PROCEDURE FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Personnel of the Eureka Union School District will cooperate with the pupil's parent/guardian and his/her authorized health care provider (MD/DO/PA) by providing a safe place for the storage of necessary medication. Selected school personnel may store and/or dispense prescription or over-the-counter medication to pupils upon written request of the pupil's parent/guardian and authorized health care provider (MD/DO/PA) only when the medication is in the original container.

BASIC LEGAL PROVISION – California Education Code, Section 49423 Notwithstanding the provision of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by **an authorized health care provider licensed by the State of California (MD/DO/PA)**, may be assisted by the school personnel if the school district has received 1.) A written statement from such health care provider detailing the method, amount and time schedules by which such medication is to be taken, and 2.) A written statement from the parent or guardian of the pupil indicating the desire that the school district assists the pupil in the matters set forth in the authorized health care provider's (MD/DO/PA) statement.

PARENT REQUEST

Student's Name _____ D.O.B. _____

4-8th School Name _____ Grade _____

The school district and its employees are not responsible for the results of this medication should any undue reaction occur. Students are not allowed to carry medications to/from/or at school with the exception of inhalers or epinephrine auto-injectors per SB 1912, AB 2132.

As the parent of the above student, in the event there is no school nurse or other licensed person to administer medication, I give consent for a trained unlicensed assistive person/trained health care aid to administer the prescribed medication to the above student. I understand I am required to pick up any medication by the last day of school, or it will be disposed of. I give the school health staff consent to communicate with the physician regarding the student's treatment plan.

Parent/guardian signature: _____ Date: _____

AUTHORIZED HEALTH CARE PROVIDER (MD/DO/PA) INSTRUCTIONS *(for each medication, all fields need to be completed by provider)*

Name Of Medication	Dosage	Diagnosis/Indication	Route	Time/Frequency

As the prescribing authorized health care provider, in the event there is no school nurse or other licensed person to administer medication, I authorize a trained unlicensed assistive person/trained health care aid to administer this prescribed medication to the above student.

MD/DO/PA signature: _____ Date: _____

MD/DO/PA signature: _____ License # _____

Phone: _____ Authorized MD/DO/PA address: _____

OPTIONAL: STUDENT MAY SELF- CARRY *(must be signed by both parent and health care provider)*

This child may carry his/her inhaler or epinephrine auto-injector with him/her and self-administer its medication. He/she has demonstrated to me that he/she can correctly use the **inhaler** or **epinephrine auto-injector**.

_____ Name of Medication(s)

MD/DO/PA Provider Signature _____ DATE _____ Parent/Guardian Signature _____

Please note: Medication orders must be renewed annually and signed by a MD/DO/PA signature licensed by the State of California. Please contact your child's school office with any questions.