EUREKA UNION SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT

5455 Eureka Road
Granite Bay, CA 95746

TK-3rd 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. ______________________________________

TK-3rd School Name ____ Grade ____

The school district and its employees are not responsible for the results of this medication should any undue reaction occur.

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: ____

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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.

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