Dear Parent or Guardian:

RE: 2025-26 School Year

Some students need to take medication during the school day, and other students may need to carry life-sustaining medication or equipment on their person **(i.e., inhaler, insulin, epi-pen, blood glucose testing equipment)**. If either of these scenarios applies to your student, please have your physician complete the attached **"Authorization for Medication Administration"** form. This form needs to be completed on an annual basis.

If your student is administering their own blood glucose tests, you'll be requested to complete an additional form. You may obtain this form from the Health Office at your student's school.

Even if school personnel are not dispensing medication to your student, it's critical that the Nurse at your student's school site ensures the proper handling and disposal of medical supplies and equipment.

If you have any questions about these procedures, please call the Nurse at your student's school.

Sincerely,

Maureen Durand, RNP-MSN
District Nurse

Linnea Goldberg, RN, BSN, MSN
District Nurse

Wendoline Castillo, RN, BSN
District Nurse

MD/LG/WC/gb

Grossmont Union High School District
AUTHORIZATION FOR MEDICATION ADMINISTRATION
Education Code 49423

I, _____ the undersigned, as legal parent/guardian of _____
Student's Name / Birthdate

attending _____ / requests that the following medicine(s): _____
School

_____

be made available to my child at the times prescribed: _____

I understand that only personnel authorized by the school principal will assist my child in taking the medicine(s) as directed by my physician.

I will provide the medicine(s) *in the prescription container(s),* which is labeled with the name of my child, the prescribing physician's name, and amount of medication prescribed.

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Prescription and nonprescription medications are not permitted to be taken at school without a written statement from the physician and a written statement from the parent indicating desire that the district assist the student as set forth in the physician's statement below.

I recognize that this is a service or accommodation that the school is not legally required to perform. I agree to save and hold the district, its officers, employees, or agents harmless from liability, suits or claims of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

_____
Signature ***Date***

_____
Home Address

_____
Home/Mobile/Work Phone Number

This form valid for school year 2025-26

THIS PORTION TO BE COMPLETED BY A PHYSICIAN LICENSED IN THE STATE OF CALIFORNIA

1. ****Name of Medication, Method of Administration, Dosage Appx., Time of Day**

A. _____

B. _____

2. Discontinue "Medication A" on _____ and "Medication B" on _____.
Date ***Date***

3. Type of assistance for administering medication (observe, measure, etc.):

_____

4. Precautions for administration or storage of medication:

_____

5. Do you wish to have school personnel contact you at intervals to discuss this medication?

☐ Yes ☐ No

Please indicate: Person(s) _____ Intervals _____
Teacher, Nurse ***Weekly, Quarterly, etc.***

****If medication is an inhaler, epi-pen, or insulin, and may be carried on person, check here ☐.**

****If glucose testing equipment will be carried on person, check here ☐.**

_____, M.D. _____
Printed Name of Physician Medical License Number

_____ _____ _____
Signature of Physician Phone Number Date