



# Medication at School Form

To be renewed annually (at least once each school year) and whenever changes in medication or authorized health care provider occur.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First M.I.  
Student ID#: \_\_\_\_\_ School: \_\_\_\_\_ Grade/Room #: \_\_\_\_/\_\_\_\_

### TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Diagnosis or Reason for Medication during the school day: \_\_\_\_\_

**If Rx is for an EMERGENCY SEIZURE MED – Do not list here. Please use reverse (or pg 2) of this form.**

Name of Medication	Dose and Frequency	Route	Time(s) to be given at school
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Possible **side effects** or other serious considerations regarding medication(s): \_\_\_\_\_

#### FOR AUTO-INJECTOR EPINEPHRINE (EpiPen):

Student is allergic to: \_\_\_\_\_

Student **may** carry EpiPen and self-administer  Yes  No (If yes, check statement below)

#### FOR ASTHMA INHALERS:

Student **may** carry asthma inhaler and self-administer  Yes  No (If yes, check statement below)

Does student need the prescribed medication \_\_\_\_\_ minutes before physical activity or sports?  Yes  No

**I have instructed the student in the proper method to use his/her  asthma inhaler and/or  EpiPen and in my opinion the student is competent to safely self-administer the medication at school.**

\_\_\_\_\_  
Health Care Provider Signature Date: \_\_\_\_\_

**DIVYA U. SIDHU, MD, MPH, FAAP** Phone: **559-224-7990**  
Health Care Provider Name / Address (Please Print)

### PARENT REQUEST AND AUTHORIZATION:

I request that the designated school personnel assist my child with medication as ordered by the health care provider. I give permission for the school nurse to communicate with the health care provider on matters related to this medication. I will notify the school nurse of any changes in medication, health status, or authorized health care provider and will provide a new medication order form. I understand I may submit a written statement to withdraw my consent for administration of medication at school at any time.

I understand that the school must receive the medication in a container with a pharmacy label that indicates name of student, health care provider's name, medication, dose, route, and time to administer (over-the-counter medication must be in the original container). I understand that the medication must be delivered to the school by the parent, guardian, or adult designee.

**I understand that my child may only take medication at school (including over-the-counter) if the school has received ALL of the following: a) Current California-authorized health care provider order, b) Parent/ guardian signature, and c) Properly labeled medication.**

**Parent Statement for Emergency Seizure Medications:** I understand emergency seizure medication at school may be administered by trained unlicensed school personnel, parent, or parent designee according to state laws and regulations.

- I will notify the school nurse if the emergency seizure medication was administered to my child within 12 hours of child attending school camp.
- I will notify the school nurse with any change in my child's seizure activity.
- I will notify the school nurse at least 2 weeks in advance if my child will be attending a field trip, including overnight camp or trip. I understand physician clearance or new medication order may be required.
- I will maintain current phone numbers with school nurse and school office in case 911 is called.
- I will provide the necessary medication, supplies, and equipment..

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_