

**AUTHORIZATION FOR PRESCRIBED AND OVER THE COUNTER MEDICATION  
ADMINISTRATION AT SCHOOLS  
WITHIN THE COUNTY OF RIVERSIDE**

Name of Student	Date of Birth	Grade	School
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Education code 49423 authorizes that any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.

- If your physician would like your child to carry either an asthma inhaler or emergency medication (auto-injectable epinephrine, i.e. Epipen), Part III must be completed by the doctor, parent and child.
- The parent or adult representative designated by the parent must bring all prescribed medications to school in its prescription-labeled container.
- Over-the-counter medications must be brought in an unopened container.
- All medications will be maintained in the Health Office with the exception of medications designated in Part III, as prescribed by the physician.
- Parent/guardian may pick up unused medications at the close of the school year. Medication remaining after the last day of school will be properly discarded.

**PHYSICIAN AUTHORIZATION  
ONE MEDICATION PER FORM**

**I. PRESCRIBED MEDICATION REQUIRED TO BE ADMINISTERED DURING SCHOOL HOURS  
(THIS SECTION IS TO BE COMPLETED BY PHYSICIAN)**

Name of medication(s)	Health condition for which medication is prescribed	
Time(s) to be taken	Dosage	
Route of administration	Precaution-possible untoward reactions	
Date to be discontinued	Special storage instructions	
Name of physician (Please print)	Physician's telephone number ( )	Fax number ( )
Physician's signature	Date	

**II. THIS SECTION IS TO BE COMPLETED BY PARENT/GUARDIAN.  
(PARTS I AND II MUST BE COMPLETED)**

I give permission for my child to receive the above medication at school according to the district board policy and administrative regulations, and agree to release, indemnify and hold harmless \_\_\_\_\_ its  
*(School/District)*  
board member, officers, agents & employees from lawsuits, claims, demands, actions or expenses that may arise against them for administering medication as set forth in accordance with the provision of part I above.

- I agree to allow communication and the exchange of pertinent medical information between medical providers and the School Nurse involved with my child's medical care.
- I understand that I may terminate consent for such administration of medication at any time, in writing.

Signature of Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**NO MEDICATION WILL BE ADMINISTERED WITHOUT THE REQUIRED SIGNATURES.**

**THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR  
OR WHENEVER THERE IS A CHANGE IN MEDICATION OR INSTRUCTIONS.  
(Self-administered medication consent form is on Page 2)**

# AUTHORIZATION AND PROTOCOL FOR SELF-ADMINISTERED MEDICATION WITHIN THE COUNTY OF RIVERSIDE

(PAGE 1 AND 2 MUST BE COMPLETED FOR SELF-ADMINISTERED MEDICATION)

Name of Student:	Date of Birth:	Grade:	School:
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In order for your child to carry a self-administered emergency medication on his/her person, the following must be understood and agreed upon by the student and parents:

The student may utilize the prescribed self-administered medication as needed and directed by his/her physician. The Doctor's signature indicates the student has been instructed on the proper use of the prescribed medication. The medication must be properly labeled with the student's name. ***Both the Authorization for Prescribed Medication form and this Protocol*** must be signed by the parent/guardian and placed on file at the school prior to your child carrying a self-administered medication on his/her person.

**Inhaler:** NO DIRECT MONITORING will be conducted by the school staff. The student is responsible for self-administration of the inhaler. If the student continues having difficulty breathing, he/she should report to the health office and the parents will be notified by the appropriate school staff.

**Self-administered emergency epinephrine:** NO DIRECT MONITORING will be conducted by the school staff. The student is responsible for notifying school staff in the event he/she had the need to self-administer the emergency medication.

- It is the parents' responsibility to immediately notify the school if the child's health status changes, or when a change in physician and/or medication occurs. Changes in procedure must be received in writing from the physician authorizing treatment.
- The district is not responsible for any risk involved with improper handling of this medication including: overuse, improper administration, breakage, theft, loss, sharing, playing with or careless storage of the medication.
- Re-evaluation of the present protocol may be needed if the student is found to display behavior that increases the safety risks of him/her self or the students on campus.

### III. PERMISSION TO CARRY AND SELF-ADMINISTER ASTHMA MEDICATION AND AUTO-INJECTABLE EPINEPHRINE (i.e. Epi-Pen)

**TO BE COMPLETED BY THE PHYSICIAN:** The above-named student has been instructed in the proper use of their asthma inhaler/emergency medication. The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the asthma inhaler/emergency medication at school. He/she is capable of self-administering the medication, understands the purpose, appropriate method, and frequency of use of the asthma inhaler/emergency medication.

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINTED/TYPED NAME OF PHYSICIAN: \_\_\_\_\_

**TO BE COMPLETED BY THE PARENT/GUARDIAN:** I permit my child to carry the above-listed asthma inhaler/emergency medication as ordered by his/her physician. I also specifically release the school district and all school personnel from any and all civil liability if my child suffers an adverse reaction as a result of self-administering medication during school hours.

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

**TO BE COMPLETED BY THE STUDENT:** I have been instructed in the proper use of my medication and will take it as prescribed to me by my physician. I understand that using my medication in a manner other than as prescribed by my doctor can result in disciplinary action taken against me by my School/District.

STUDENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Please return the fully completed forms to your child's school health office signed by the physician, parent/guardian, and student. Medication forms must be renewed at the beginning of each school year or whenever there is a change in medication or instructions.

**NO MEDICATION WILL BE ALLOWED WITHOUT THE REQUIRED SIGNATURES.**