Form #520.4A
Revised 5/99

GLENDORA UNIFIED SCHOOL DISTRICT

AUTHORIZATION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

California Education code 49423 allows designated school personnel to assist students who are required to take medications during the school day. This service is provided to enable the student to remain in school to maintain or improve the potential for education and learning. Medication must be in the original container in which it was purchased with the pharmacy label attached and must be prescribed to the student to whom it will be administered during the school day. No medications, including over the counter medication will be given at school without a current medication authorization signed by a licensed MD/Nurse Practitioner/Dentist or other State Licensed DEA holder.

Student's Name:_____

School:_____ Grade: _____

Date:_____ Teacher: _____

**************TO BE COMPLETED BY HEALTH CARE PROVIDER***************

Name of Medication: _____

Reason for Medication: _____

Route: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Other

Dose: _____ **Specific time <u>during school hours</u> to be administered:** _____

Side effects: ☐ None anticipated. ☐ _____

Storage requirement: ☐ None ☐ Refrigerate

Physician Name:_____ Physician Signature: _____

Address: _____ City/Zip: _____

Phone Number: (____)_____ Fax Number: (____)_____

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To be completed by Parent/Guardian

I give my permission for my child to receive the above medication at school according to the Glendora Unified School District Medication Board Policy and in compliance with California Education Codes.

Date: _____ Parent Signature: _____

Glendora Unified School District

Waiver for SELF ADMINISTRATION OF MEDICATIONS During School Hours

According to Glendora Unified School District Board Policy and California Administrative Code, medications are to be administered by designated school personnel following physician orders and kept away from student contact. Students who must self administer or carry medications for independent administration must have a medication waiver on file. This waiver statement indicates that both the parent and physician deem that this student is capable and responsible to carry and self administer medication listed below without staff supervision, monitoring or assistance.

Student's Name:_____

School:_____ Grade: _____

Date:_____ Teacher:_____ School Year: _____

**************TO BE COMPLETED BY HEALTH CARE PROVIDER**************

Name of Medication: _____

Reason for Medication: _____

Route: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Other

I deem that this student is capable and responsible to carry and self administer this medication without staff supervision, monitoring or assistance.

Physician Name: _____ Physician Signature: _____

Address: _____ City/Zip: _____

Phone Number: (___) _____ Fax Number: (___) _____ Date: _____

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To be completed by Parent/Guardian

I deem that my child is capable and responsible to carry and self administer this medication without staff supervision, monitoring or assistance.

Date: _____ Parent Signature: _____

This form *MUST* be completed annually.
Students who demonstrate behavior or actions that would conflict with responsible or safe use of this medication will have the waiver revoked, and medication will need to be dispensed through the school office for the safety of all students

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