SCHOOL YEAR 20___ to 20___

Coronado Unified School District

MEDICATION AUTHORIZATION AND PLAN

IHP ____ 504____

*All students receiving medication at school require a Medication Authorization and Plan. This authorization may serve as an Individual Health Plan (IHP) for Special Education students or a Section 504 for other students. Prescription and non-prescription medications are permitted at school only when this completed form is on file. If any of the conditions of this authorization change, a new form must be completed and signed by the parent **and** health provider. A fax copy may be accepted until the original can be mailed or brought to the health office. This form is valid for **one** school year and must be renewed annually.*

HEALTH CARE PROVIDER SECTION

_____ has been instructed in the proper use of the following medication(s). In
(student name)
In my professional opinion this student **MAY/MAY NOT** carry and use this medication himself/herself. If not, I hereby instruct a designated school staff member to assist this student in taking:

MEDICATION	Dose	Route	Time	Diagnosis/Condition

ASTHMA Peak Flow Zones : Green _____ **Yellow** _____ **Red** _____

Side effects that may be experienced while taking this medication: _____

Other medication taken by this student: _____

Emergency plan: _____

_____

Date: ___ / ___ / ___ _____ MD / DO / DDS / DPM / NP / PA
Printed name of provider

_____ _____ _____
CA License # **Signature** of provider Contact number

(For school use) _____ ___ /___ /___
Reviewed / approved by school nurse

PARENT SECTION

_____ ___ / ___ / ___ _____ _____
Student Name Birthdate School Grade

I, the undersigned as legal parent / guardian of above student, request a designated member of the school staff make available the above listed medication(s) to my child as prescribed on this authorization and in accordance with California law as referenced below. I also authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed above. I will comply with the procedure listed on the back of this form related to the dispensing and safety of medication at school.

____ / ___ / ___ _____ _____
Date Parent / Guardian Signature Student Signature (for self medication)

_____ _____ _____
Home Address Home Phone Work Phone

REFERENCES: *California Education CodeSection:* **49423** Medication at school; **49480** Continuing Medication. *Business and Professional code:* **2725** Verbal Orders; **4033** Definition of a Physician; **4036** Definition of a lawful prescription; **4051** Restrictions on furnishing medications without prescriptions.

ONLY prescription and non-prescription (including over the counter) **medication** prescribed by student's health provider **listed** on the front of this form **may be brought** to school and can only be administered if **all** conditions below are met:

- ✓ Both health care provider and parent sections are completed, signed, and brought to health office.
- ✓ Medication is brought to school by parent or responsible student (generally 6th grade or above) in prescription or manufacturer's container labeled with:
  (Many pharmacies will give a second "school medication bottle" on request)
  - Student name
  - Prescribing provider name
  - Name of dispensing pharmacy or manufacturer
  - Strength of medication and dose
  - Method of administration
  - Time and/or specific situation medication is to be given

- ✓ If physician **circles** and approves **self medication,** only **one day's dose** may be brought to school per day and student assumes responsibility for medication safety. Credentialed School Nurse will approve ability and safety to self medicate to ensure the student is physically, mentally, and behaviorally capable to assume this responsibility at school.
- ✓ The medication is necessary to the student's health and must be taken during school hours.

Medication authorization is valid for **one school year** unless ordered discontinued**.** A **new form** must be completed for **any change** in dose, time, or method of administration. Authorization may serve as an Individual Health Plan (IHP) or as a section 504 Plan for those students who qualify.

All medication will be kept in a secure place. Any special instructions for storage or security must be written by the health care provider and given to the school Health Personnel.

Medication must be picked up by the parent/guardian within one day of the end of the school year or they will be discarded.

Questions regarding medication should be directed to your Credentialed School Nurse. The Health Technicians provide general information and can direct you to the location and phone number of the District Nurse.

FOR OFFICE USE ONLY

Medication _____ *Student* _____
Dosage _____ *Time* _____ *Grade* _____ *Room* _____
Date Form In _____ /_____ /_____ *Teacher* _____

DATE	TIME	Pk. Flow	DOSE	INIT

DATE	TIME	Pk. Flow	DOSE	INIT

INITIALS *Name (Printed)* *Signature*

_____ _____ _____
_____ _____ _____