

# Authorization for Medication

*Return form to school with Parent and Health Care Provider signatures*

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent's Name \_\_\_\_\_ Phone (home) \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone (home) \_\_\_\_\_ Cell \_\_\_\_\_

When the district has received written orders from the student's physician and written permission from the parent/guardian, the school nurse or other designated personnel under supervision of the EUSD school nurse shall **assist** the student in taking the medication. All medication must be brought to school in an **original container and appropriately labeled** by the pharmacist. Parents/guardians may request that the pharmacist dispense two bottles of medication, one for home and one for school. Written permission must also be provided for students to carry and self-administer prescribed medication. (CA Education Code 49423; EUSD Board Policy 5141.21).

## To Be Completed By Health Care Provider

Name of Medication or Treatment	Reason	Dosage	Route	Time	Refrigerate? (Y/N)	Self-Administer?	Self-Carry? (Y/N)
						<input type="checkbox"/> No <input type="checkbox"/> Yes, supervised <input type="checkbox"/> Yes, unsupervised	
						<input type="checkbox"/> No <input type="checkbox"/> Yes, supervised <input type="checkbox"/> Yes, unsupervised	
						<input type="checkbox"/> No <input type="checkbox"/> Yes, supervised <input type="checkbox"/> Yes, unsupervised	
						<input type="checkbox"/> No <input type="checkbox"/> Yes, supervised <input type="checkbox"/> Yes, unsupervised	

Diagnosis/Significant Findings: \_\_\_\_\_  
 Allergies (Medication/Other substances) \_\_\_\_\_

### This Box Only Needs To Be Completed If Student Has ASTHMA

**To provide assistance to a student experiencing asthma symptoms:**

**If you see or hear the following symptoms, follow Health Care Provider Orders**

- Noisy breathing • Coughing • Shortness of breath • Complaint of chest tightness • Difficulty breathing • Other \_\_\_\_\_

**Health Care Provider Orders**

1. Stay with student, speak softly, and stay calm
2. Keep student sitting upright and encourage slow deep breathing
3. Give quick relief medication Albuterol Inhaler 2 puffs **with spacer**  
 Other quick relief medication: \_\_\_\_\_ Location of medication: \_\_\_\_\_  
(School to complete)
4. Have helper call guardian and school nurse
5. If symptoms do not improve, repeat in 5-10 minutes.
6. **Call 911** if you see any of the following: **Student having trouble walking or talking, stooped body posture, skin pulling in around collarbone and ribs with breathing, continuous coughing, or lips or fingernails turning gray, blue, or purple**  
**May give 3-4 puffs albuterol every 20 minutes (3 times maximum) until medical help arrives.**

Does student need medicine before PE or sports?  No  Yes  
 Albuterol Inhaler- 2 puffs with spacer, 15-20 minutes before exercise; Other quick relief medication \_\_\_\_\_

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

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**To be completed by parent or guardian:**

I authorize the school nurse and/or other trained school personnel to assist my child in taking his/her medications and treatments, and I authorize the nurse to consult with the Health Care Provider about my child's medical needs as necessary while my child is at school.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_