EUREKA UNION SCHOOL DISTRICT

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TK-3rd ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

PROCEDURE FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL
Personnel of the Eureka Union School District will cooperate with the pupil's parent/guardian and his/her authorized health care provider (AHCP) by providing a safe place for the storage of necessary medication. Selected school personnel may store and/or dispense prescription or over-the-counter medication to pupils upon written request of the pupil's parent/guardian and AHCP only when the medication is in the original container.

BASIC LEGAL PROVISION – California Education Code, Section 49423 Notwithstanding the provision of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for them by an AHCP, may be assisted by the school personnel if the school district has received 1) A written statement from such health care provider detailing the method, amount and time schedules by which such medication is to be taken, and 2) A written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the AHCP's statement.

PARENT REQUEST
Student's Name _____ Date of Birth _____

TK- 3rd School Name _____ Grade _____

The school district and its employees are not responsible for the results of this medication should any undue reaction occur.

As the parent of the above student, in the event there is no school nurse or other licensed person to administer medication, I give consent for a trained unlicensed assistive person/trained health care aid to administer the prescribed medication to the above student. I give the School Nurse consent to communicate with the AHCP regarding the student's treatment plan.

Parent/guardian signature:_____Date: _____

AUTHORIZED HEALTH CARE PROVIDER (AHCP) INSTRUCTIONS

Medication/Dosage/Time/Frequency/Route ofadministration: _____

Diagnosis and indication for medication: _____

Special instructions/precautions/side effects: _____

As the prescribing AHCP, in the event there is no school nurse or other licensed person to administer medication, I authorize a trained unlicensed assistive person/trained health care aid to administer this prescribed medication to the above student.

Authorized Health Care Provider's signature:_____Date: _____

Authorized Health Care Provider's printed name:_____Phone:_____

Authorized Health Care Provider's address: _____

Please Note: Medication orders must be renewed annually and signed by an authorized health care provider licensed by the State of California. Please contact your child's school office with any questions.