SANTA MONICA – MALIBU UNIFIED SCHOOL DISTRICT

Department of Health Services

Medication at School Form

This form must be renewed at the beginning of each school year and whenever there is a change in the medication order.

Student Name: _____ Date of Birth: _____
Last First MI

School: _____ Student ID #: _____ Grade: _____

TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER

Diagnosis or Reason for Medication during the school day: _____

Name of Medication	*Method of Administration*	*Dosage*	*Time(s) to be given*	*Frequency & Symptoms for "as needed"*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Precautions, reactions, or side effects: _____

Medication to be administered by: ☐ Designated Unlicensed School Personnel (indirect supervision by a licensed nurse)

In my professional opinion this student: May ☐ / May Not ☐ carry (ONLY) asthma inhalers, auto-injectable epinephrine or Insulin/diabetic supplies.

_____ _____
Authorized Health Care Provider Signature *Date*

_____ _____
Health Care Provider Name/Address (print) *Phone Number*

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I request that the school assist my child with medication as ordered by the health care provider. I give permission for the school nurse to communicate with the health care provider on matters related to these medications.

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, health care provider's name, medication, dose, method of administration, and time to administer (over-the-counter medications must be in the original containers). The medication must be delivered to the school by the parent, guardian or adult designee.

I understand that my child may only take the medications at school (including over-the-counter) if the school has received ALL of the following: 1.) Current California authorized health care provider order, 2.) Parent/guardian signature, and 3.) Properly labeled medications.

I authorize a designated member of the school staff to assist my student with medication as ordered by the health care provider:

_____ _____ _____ _____
Parent/Guardian Name (Print) ***Parent/Guardian Signature*** *Date* *Phone Number*