Carondelet High School

Concord, California

AUTHORIZATION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

Student Name _____ Birthdate _____ Grade ____

Parent/Guardian _____ Phone _____

Education Code 49423, 49423.1 Any pupil who is required to take, during the regular school day, medication prescribed for him/her by a licensed healthcare provider, may be assisted by the school nurse or other designated school personnel or may carry and self-administer prescription auto-injectable epinephrine or inhaled asthma medication if the school district receives a written statement from the healthcare provider detailing the name of the medication, method, amount, and time schedules.

PART I—PARENT/GUARDIAN AUTHORIZATION *(to be completed by parent/guardian)*

I hereby request volunteer unlicensed school personnel to safely store and, in the event that medication is needed, observe my child with taking medication(s) below according to my healthcare provider. I understand all medication must be in the original appropriately labeled container. I also give consent for exchange of information between the healthcare provider and Carondelet High School personnel to communicate on matters related to this medication. I hereby release the school and school personnel from civil liability if the student suffers an adverse reaction as a result of self-administering the medication. I understand I am required to pick up medication within one week after the last day of school or the medication will be disposed of.

Parent/Guardian Signature : ***Date:***

PART II—HEALTHCARE PROVIDER AUTHORIZATION *(to be completed by provider)*

Name of Medication	Diagnosis / Indication	Dosage	Route	Time / Frequency

Medication must be in its original container and labeled as above. Please attach a list of potential side effects of the above prescribed medications. I acknowledge volunteer unlicensed school personnel may assist the student with the above prescribed medications.

Healthcare Provider's Signature: ***Date:***

Please Print or Stamp → Provider Name Practice Name / Address Contact Phone	

PART III—OPTIONAL STUDENT SELF-CARRY / SELF-ADMINISTRATION

Student may self-carry and administer:	
Student has been instructed and shows competency in use of listed medication(s).	Name of Medication(s)

Healthcare Provider Signature: ***Date:***

Parent/Guardian Signature: ***Date:***