UPWARD INTERNATIONAL SCHOOLS

AUTHORIZATION FOR MEDICATION TO BE GIVEN AT SCHOOL

SELECT CAMPUS:

___ Pines Academy Campus
___ UIS Paradise
___ Upward Learning Centre 1
___ Upward Learning Centre 2

California Education Code, Section 49423, provides that any student required to take, during regularschool days, medications prescribed by a physician may be administered by designated schoo lpersonnel if the school receives specified written orders from such physician and the parent/guardian of the student.

Student Name: _____ **Birth Date:** _____

PHYSICIAN'S AUTHORIZATION to give medication at school (to be completed by the physician):

1) **Medication and Strength:** _____
2) **Amount of medication (number of capsules, tablets, tsp.)** _____
   Time of day to be given: _____
   Purpose of medication: _____
   Possible side-effects: _____
   □ **Check box if you (physician) approve that it is medically necessary for the student (6-12 grade) to carry the above prescribed INHALER/EPIPEN with him/her during schools hours, and you (physician) have observed and approved the student's techniques of self-administration.**
3) **Medication and Strength:** _____
   Amount of medication (number of capsules, tablets, tsp.) _____
   Time of day to be given: _____
   Purpose of medication: _____
   Possible side-effects: _____
   □ **Check box if you (physician) approve that it is medically necessary for the student (6th-12th grade) to carry the above prescribed INHALER/EPIPEN with him/her during schools hours, and you (physician) have observed and approved the student's techniques of self-administration.**
4) **Medication and Strength:** _____
   Amount of medication (number of capsules, tablets, tsp.) _____
   Time of day to be given: _____
   Purpose of medication: _____
   Possible side-effects: _____
   □ **Check box if you (physician) approve that it is medically necessary for the student (6th-12th grade) to carry the above prescribed INHALER/EPIPEN with him/her during schools hours, and you (physician) have observed and approved the student's techniques of self-administration.**

I hereby authorize school personnel to administer the above medications(s) as directed:

Physician's Signature: _____ **Date:** _____

Physician's PRINTED Name: _____ **Phone:** _____ **Fax #** _____

Physician's Address: _____

PARENT'S AUTHORIZATION for exchange of information and administration of medication at school:

1. I approve of this authorization for medication to be given to my child by school personnel as indicated by my child's physician on this medication form.
2. I also give permission for the exchange of information contained in the record of my child between the above named doctor and UIS, Pines Academy.
3. I also give consent to the self-administration if approved by my physician and release UIS, Pines Academy and school personnel from civil liability if the student suffers adverse reaction as a result of self-administering the medication.

Parent/Guardian Signature: _____ **Date:** _____ **Emergency Phone:** _____

Parent/Guardian PRINTED Name: _____ **Alternate Phone(s):** _____

- Authorization for Medication Form MUST be signed by parent/guardian AND physician before any medication(s) is given by school personnel.
- Medications must be brought to the school by the parent/guardian unless another method of delivery is authorized by the school administrator or designee. (ALTERNATIVE DELIVER _____ Authorized by _____)
- ALL medications must be in ORIGINAL and CURRENT PRESCRIPTION BOTTLES.
- Authorizations for medication in school must be completed each year for long term medications.
- This form is valid for CURRENT school year only and must be renewed each school year.

SCHOOL ADMINISTRATOR/DESIGNEE SIGNAURE: _____ **Date:** _____ Rev. 180215

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