ST. HELENA UNIFIED SCHOOL DISTRICT
MEDICATION ASSISTANCE AUTHORIZATION

Student Name:_____Student ID:_____D.O.B._____

Address: _____

School:_____Grade:____ Teacher:_____

Parent/Guardian Phone: Home:_____ Work:_____Cell:_____Emergency:_____

IMPORTANT INFORMATION

In accordance with California Education Code Section 49423, Section 504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act of 1990, students who have a Medical Disability for which a physician has prescribed Medication to be taken during the school day, whether of limited or permanent duration, are entitled to seek assistance from the District in meeting their Medication needs when the student is under the District's care, custody, or control, including while the student is on field trips, sporting events, and other off-campus District-sponsored activities. **Except for personal asthma inhalers and personal epi-pens, a student may not independently possess Medication during the school day or while on District property**. Due to health and safety concerns, including the potential theft of the Medication or the potential for improper sharing/use of the Medication by other students who may then suffer unexpected allergic or other negative reactions, **there are no exceptions to this requirement**. A student personally possessing Medication, misusing Medication, or providing Medication to another student, may face discipline.

> ***Medication****, means currently (unexpired) prescribed Medications, as well as over-the-counter remedies (such as aspirin, decongestant, eye drops) and nutritional/herbal supplements. Because several over-the-counter medications can present safety or health hazards to others, all Medications are subject to the following rules and regulations.*
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> ***Medical Disability****, means any mental or physical condition limiting a student's ability to engage in major life activities (such as eating, breathing, hearing, speaking, learning, or performing self-care) or which otherwise is subject to a medical disability or condition for which Medication has been prescribed or recommended by a physician.*
>
> ***Medication Assistance****, means the storage of Medication, or the providing of Medication to a student in accordance with a physician's written instructions or directives, when the child presents himself/herself at the agreed time, or in response to urgent or emergency circumstances. As permitted by law, assistance may be provided by a District employee other than a nurse or licensed or trained medical care provider. Any emergency assistance provided to a student will be promptly brought to the attention of the parent/guardian. All additional reports/reporting of emergency Assistance will be undertaken in keeping with governing laws and District policies and procedures.*

Before Medication Assistance can be provided, even if the student has an Individualized Education Plan ("IEP") or a "504 Plan," this Medication Assistance Authorization form ("Authorization") must be executed by at least one parent/legal guardian **and** the student's duly authorized health care provider. A new Authorization is required at the beginning of each school year **and** any time there is a change in Medication directives (such as change in Medication, dosage, timing, or frequency). The parent/legal guardian must immediately notify the District of any change in Medication directives.

All Medication must be provided to the District by a parent/legal guardian, with the District storing the Medication and dispensing it in compliance with the Medication directive. All medication supplied to the District must be in its original labeled form (i.e., in the original prescription bottle, sealed package, etc.) as received from the physician, pharmacist, or store. Until the District receives an updated Authorization, signed by the parent/legal guardian and health care provider, the District will continue to provide the provided Medication, and provide Medication Assistance according to an existing Authorization, unless (a) there is evidence the student's health may be endangered by the continued use of the former Medication directive, or (b) the parent/legal guardian provides a written statement that Medication Assistance is to cease or be suspended until the new Authorization can be provided. In such situations, the parent/legal guardian will need to provide the Medication Assistance to the student at agreed times during the school day in a safe and appropriate manner that does not unduly disrupt the educational environment.

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PARENT/GUARDIAN AUTHORIZATION

I have read, understand, and agree to be bound by the rights and obligations contained in the Important Information section of this Authorization. I request that Medication Assistance be provided to my Student.

The Student understands his/her obligations described in the Important Information section above, including the need to ensure he/she complies with the directions for receiving Medication Assistance (i.e., coming to the school or nurse's office each day, at the same time, without need for a District employee to attempt to locate them) and the policy against his/her personal possession or sharing of Medication (except for asthma inhalers and epi-pens). I understand that if the Student fails to meet these obligations that he/she may face discipline and/or this Authorization may be revoked.

Unless required by law, I understand there is no guarantee that Medication Assistance will be performed by a nurse or licensed health care provider, although the District will take reasonable steps to ensure that the District employee providing Assistance has received training that complies with all legal requirements. As a partner with the District in protecting the Student's health and safety, I will work with school staff regarding Medication Assistance issues, including Medication Assistance issues when the Student is expected to be involved in off-campus District-sponsored activities. I will also timely advise the District of any change in Medication directives. It is my responsibility to obtain a new Authorization form, signed by a licensed health care provider, when there is a change in Medication directives. I will comply with my responsibilities described above should those Medication directives change.

With respect to the Medication Assistance issues covered by this Authorization, I authorize the District and the health care provider below to discuss the student's medical and/or Medication information, I authorize the health care provider to provide any additional information to the District as may be necessary to carry out this Authorization, and I authorize the disclosure of this information to all District employees and trained volunteers who may supervise, or regularly interact with, the Student.

_____	_____	_____
Date	Signature Parent/Guardian	Printed Name Parent/Guardian

PHYSICIAN AUTHORIZATION

_____ (student name) is under my care and I have personally direct the following: **(If more than two medications are prescribed, or more explanation is needed, physically attach to this Authorization a separate signed sheet noting the additional information)**

1st Med. Name	Dosage	Method of Admin.	Duration (date/week/month/until discontinued)
	☐ Regular (if yes, add Interval/Time of Day)	☐ Emergency basis (Must Describe Symptoms/Triggers)	☐ As Needed (Must Describe Symptoms/Triggers)
Student capable of self-administering? ☐Yes ☐No		Student may/should carry medication? ☐Yes ☐No (applies only to inhalers/epi-pens)	
Must a District employee have special training/experience before providing assistance? ☐Yes ☐No (If yes, describe the training/experience).			
Post Assistance Care/Potential Adverse Reactions/Follow-up/Emergency Care:			
2st Med. Name	Dosage	Method of Admin.	Duration (date/week/month/until discontinued)
	☐ Regular (if yes, add Interval/Time of Day)	☐ Emergency basis (Must Describe Symptoms/Triggers)	☐ As Needed (Must Describe Symptoms/Triggers)
Student capable of self-administering? ☐Yes ☐No		Student may/should carry medication? ☐Yes ☐No (applies only to inhalers/epi-pens)	
Must a District employee have special training/experience before providing assistance? ☐Yes ☐No (If yes, describe the training/experience).			
Post Assistance Care/Potential Adverse Reactions Requiring Follow-up/Emergency Care:			

Additional Remarks/Directions_____

Physician's Name _____ Medical License No. _____
Address _____ Telephone Number _____
Physician s Signature_____ Date _____