Grossmont Union
High School District
COMMITTED TO EXCELLENCE
SINCE 1920

Dear Parent or Guardian:

Some students need to take medication during the school day. If this applies to your son/daughter, please have your physician complete the attached **"Authorization for Medication Administration"** form. This form needs to be completed on an annual basis.

Other students need to carry emergency or life-sustaining medication or equipment on their person **(i.e., inhaler, insulin, epi-pen, blood glucose testing equipment)**. If this applies to your son/daughter, your physician also needs to complete the attached **"Authorization for Medication Administration"** form on an annual basis.

If your son/daughter is administering his/her own blood glucose tests, you'll be requested to complete an additional form. You may obtain this form from the Health Office at your student's school.

Even if school personnel aren't dispensing medication to your son/daughter, it's critical that the site LVN ensures the proper handling and disposal of medical supplies and equipment.

If you have any questions about these procedures, please phone the LVN at your son's/daughter's school.

Sincerely,

Jackie Doria
District Nurse

Linnea Goldberg
District Nurse

JD/LG/djm
Attachment

POST OFFICE BOX 1043 LA MESA CALIFORNIA 91944-1043
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Grossmont Union High School District
AUTHORIZATION FOR MEDICATION ADMINISTRATION
Education Code 49423

I, the undersigned, as legal parent/guardian of _____ (Student's Name)

_____ (Birthdate) attending _____ (School) requests that the following medicine(s):

_____

be made available to my child at the times prescribed _____.

I understand that only personnel authorized by the school principal will assist my child in taking the medicine(s) as directed by my physician.

I will provide the medicine(s) *in the prescription container(s),* which is labeled with the name of my child, the prescribing physician's name, and amount of medication prescribed.

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Prescription and nonprescription medications are not permitted to be taken at school without a written statement from the physician and a written statement from the parent indicating desire that the district assist the student as set forth in the physician's statement below.

I recognize that this is a service or accommodation that the school is not legally required to perform. I agree to save and hold the district, its officers, employees, or agents, harmless from a liability, suits or claims of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

_____ (Signature) _____ (Date)

_____ (Home Address)

_____ (Home Telephone) _____ (Work Telephone)

This form valid for school year 2013-14.

THIS PORTION TO BE COMPLETED BY A PHYSICIAN LICENSED IN THE STATE OF CALIFORNIA

1. ****Name of Medication** **Method of Administration** **Dosage Appx.** **Time of Day**

   A. _____

   B. _____

2. Discontinue "Medication A" on _____ (Date) and "Medication B" on _____ (Date).

3. Type of assistance for administering medication (observe, measure, etc.):

   _____

4. Precautions for administration or storage of medication:

   _____

5. Do you wish to have school personnel contact you at intervals to discuss this medication?

   ☐ Yes ☐ No Please indicate: Person(s) _____ (Teacher, Nurse), Intervals _____ (Weekly, Quarterly, etc.)

****If medication is an inhaler, epi-pen, or insulin, and may be carried on person, check here ☐.**
****If glucose testing equipment will be carried on person, check here ☐.**

_____ M.D. (Printed Name of Physician) _____ (Medical License Number) _____ (Telephone Number)

_____ (Signature of Physician) _____ (Date)