The Procedure covering prescription and **nonprescription** medication listed on this form will be expedited under the following conditions:

1. Only the medication prescribed by the pupil's physician as being necessary to be taken by the pupil in the manner listed on this form should be brought to school. Parent Signature on this form indicates parent consent for authorized school personnel to assist their student in taking their prescribed medication.

2. Such medication should be taken by the pupil in accordance with instruction from the physician as listed on this form.

3. Medication brought to school to be given to the pupil according to the provisions listed on this form should be in prescription containers which are clearly marked with the name of the pupil; the name of the prescribing physician; the druggist who dispensed the medication or the manufacturer; and the amount of the medication to be taken at specified times or in specific situations, etc. (Parents may want to ask the physician for a prescription for a duplicate supply, one for home and one for school.)

4. For medication that is self-administered by the student (including Auto Inject-able Epinephrine) the Charter School and school personnel shall be held harmless from civil liability if the self-administering pupil suffers an adverse reaction as a result of self-administering medication.

5. All medication will be kept in a secure place. Any special instructions for storage or security measures of any medication should be written by the physician and given to school personnel so that such instructions can be followed.

6. Parent or designated adult shall deliver the medication and the completed form to the school health office.

7. A new medication authorization must be renewed for each school year if a continuance of medication is necessary.

8. Controlled substances will be counted and signed for by the designated adult delivering the medication.

9. When a physician prescribes over-the-counter or non-prescription medication, it should be kept in its original container.

10. Homeopathic medicines, herbs, and vitamins require a medical authorization form completed by your physician.

I have read and agree with the terms above and desire that authorized charter school personnel assist my child with their medical needs

____

Student Name

____________________________________ ____________________________

Signature of Parent/Guardian Date

College Preparatory Middle School – La Mesa Spring Valley

Health Services

AUTHORIZATION FOR MEDICATION ADMINISTRATION
(Education Code 49423)

This form is valid for school year ________ to ______ only.

I, the undersigned, as legal parent or guardian of _____________________________ birth date _____________ attending College Preparatory Middle School – La Mesa Spring Valley request that the following medicine(s) _____________________________ be made available to my child at the times prescribed.

I understand that only personnel authorized by the school 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/are labeled with the name of my child, the prescribing physician name, and the 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 school assist the student as set forth in the Physician's Statement below.

Signature__________________________________ Date________________

Home Address ___________________________________ Phone________________

This portion to be filled out by a physician licensed in the State of California

Name of Medication	Method of Administration	Dosage	Appx. Time of Day
1.			
2.			

Discontinue medication #1 on: ____________________ and Medication #2 on:______________________

Diagnosis: _____________________________ Reason for giving medication _______________________

Precautions for administration or storage of Medication:

____

____

Do you wish school personnel to contact you at intervals to discuss this medication? Yes or No (please circle)

_____________________________**M.D.** _____________________________ _______________________

Printed Name of Physician **Medical License Number** **Telephone Number**

Signature of Physician:_______________________________ **Date:**____________________