

**MT. DIABLO UNIFIED SCHOOL DISTRICT**

**AUTHORIZATION TO ADMINISTER MEDICATION DURING SCHOOL HOURS**

**Ed. Code. 49423** Any pupil who is required to take during the regular school day, medication prescribed for him or her by a physician and surgeon, may be assisted by the school nurse or other designated school personnel or may carry and self-administer inhaled asthma medication or may carry and self-administer prescription auto-injectable epinephrine if the school district receives (1) a written statement from such physician detailing the method, (2) a written statement from the parent/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician statements.

**MDUSD Administrative Rule 5141.2(a)** The administration of medication to pupils shall be done only in exceptional circumstances wherein the child's health may be jeopardized without it and only when such administration has been requested and approved by the student's parent/guardian and physician.

**PART I—PARENT AUTHORIZATION:** *(To be completed by parent/guardian.)* My child requires the administration of medication during the school day and I request that he/she be assisted by designated school personnel. I give my consent for exchange of information between the physician/health care provider and Mt. Diablo Unified School District designated school personnel.

Name of Student \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

\_\_\_\_\_  
Signature Relationship (parent, guardian, sister, etc.) Date \_\_\_\_\_

**PART II—PHYSICIAN AUTHORIZATION:** *(To be completed by the student's physician.)* Because of the health condition of the above named student and the nature of the medication I have prescribed, the administration of the medication must be provided during school hours. I understand that this medication order must be renewed yearly.

Medication	Dosage	Method of Administration	Frequency	Time/Interval
Health condition for which medication prescribed:		Remarks		
Name of Physician _____ Print/Stamp		Signature _____	Date _____	
Address _____		Telephone _____	FAX _____	

The above named student has been instructed and can show competency in the use of their life-sustaining medication. The child's well being is in jeopardy unless this **medication is carried on his/her person.**

\_\_\_\_\_  
Physician Signature Date Parent / Guardian Signature Date

Return form to \_\_\_\_\_ Telephone \_\_\_\_\_ FAX \_\_\_\_\_

**Approved** \_\_\_\_\_ **Date** \_\_\_\_\_  
School Principal

White - Original to School  
Canary - Parent  
Pink - Physician