Central Union High School District 351 Ross Ave, El Centro, CA 92243
Christina Wilkinson, RN PHONE (760) 336-4272 FAX (760) 352-9772

Parent Consent and Authorized Health Care Provider Authorization for Management of Medication Administration at School and School-Sponsored Events

Student:	Date of Birth:	Grade:
School:	Teacher:	School Year:

1. **Name of medication** (one medication per form): _____
   ☐ Prescription ☐ Over-the-counter (non-prescription) ☐ Controlled medication
2. **Reason for medication**: _____
3. **Method of administration:**
   ☐ oral ☐ g-tube ☐ nebulizer ☐ inhaled ☐ injection ☐ topical ☐ Other: _____
4. **Amount/Dosage of medication** (be specific, i.e., ml, mg, etc.): _____
5. **Time(s) of day to be given at school:** _____
   ☐ As needed **PRN** Frequency: _____
   List specific symptoms that would necessitate administration of the **PRN** medication and indications for referral for a medical evaluation: _____
   _____
   _____
6. **Possible side effects**: _____
7. **Additional recommendations**: _____
   _____

Authorized Health Care Provider Authorization for Management of Medication Administration in School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

☐ **In my professional opinion, the above named student is competent to safely carry and self-administer the above named medication according the condition(s) in the above written statement.**

Authorized Health Care Provider Name_____ **Signature**_____

Phone_____ **Address**_____ **City**_____ **Zip**_____ **Date** _____

Parent Consent for Authorization and Management of Medication Administration in School Setting

I the undersigned, the parent/guardian, of the above named student, request that the specialized physical health care service, medication administration be administered to my child in accordance with state laws and regulations.

1. I give consent for the school nurse, other duly qualified supervisor of health, or site administrator to communicate with the authorized health care provider and the pharmacist with regard to the provider's written statement.
2. I will provide the necessary medication, supplies and equipment.
3. I will notify the school nurse, other duly qualified supervisor of health, or the site administrator if there is a change in child's medication, health status or authorized health care provider.
4. I will notify the school nurse, other duly qualified supervisor of health, or site administrator immediately and provide new consent for any changes in authorized health care provider's authorization.

☐ **I, the parent/guardian of the above named student, request that my child carry and self-administer his/her medication as authorized above.**

Signature of Parent/Guardian_____ **Date**_____

NOTE During early dismissal days and Extended School Year Program, Specialized Physical Health Care Procedures ordered on or after dismissal time will not be administered at school. Parent/guardian to provide at home. (Excluding "Emergency" SPHCS).

Reviewed by school nurse (Signature):_____ Date: _____

IMPERIAL COUNTY SCHOOL HEALTH AUTHORIZATION 351 Ross Ave, El Centro, CA 92243 (CUHSD)
Christina Wilkinson, RN PHONE (760) 336-4272 FAX (760) 352-9772

Consentimiento de los padres y autorización autorizado proveedor de atención médica para la Gestión de la Administración de Medicamentos en la escuela y eventos patrocinados por la escuela

Estudiante:	Fecha de Nacimiento:	Grado:
Escuela:	Maestro:	Eduque Año:

1. **Name of medication** (one medication per form): _____
   ☐ Prescription ☐ Over-the-counter (non-prescription) ☐ Controlled medication
2. **Reason for medication**: _____
3. **Method of administration:**
   ☐ oral ☐ g-tube ☐ nebulizer ☐ inhaled ☐ injection ☐ topical ☐ Other: _____
4. **Amount/Dosage of medication** (be specific, i.e., ml, mg, etc.): _____
5. **Time(s) of day to be given at school:** _____
   ☐ As needed **PRN** Frequency: _____
   List specific symptoms that would necessitate administration of the **PRN** medication and indications for referral for a medical evaluation: _____
   _____
   _____
6. **Possible side effects**: _____
7. **Additional recommendations**: _____
   _____

Authorized Health Care Provider Authorization for Management of Medication Administration in School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

☐ **In my professional opinion, the above named student is competent to safely carry and self-administer the above named medication according the condition(s) in the above written statement.**

Authorized Health Care Provider Name_____ **Signature**_____

Phone_____ **Address**_____ **City**_____ **Zip**_____ **Date** _____

Consentimiento de los padres para la autorización y gestión de la administración de medicamentos en la escuela Marco

El que suscribe, el padre o tutor, del estudiante antes mencionado, solicitamos que el servicio especializado de atención de la salud física, administración de medicamentos se administran a mi hijo, de acuerdo con las leyes estatales y regulaciones.

1. Doy mi consentimiento para la enfermera de la escuela, otro supervisor debidamente calificado de la salud, o administrador del sitio para comunicarse con el proveedor de asistencia sanitaria autorizado y el farmacéutico en lo que respecta a la declaración escrita del proveedor.
2. Voy a ofrecer la necesaria medicación, suministros y equipo.
3. Voy a notificar a la enfermera de la escuela, otro supervisor debidamente calificado de la salud, o el administrador del sitio si hay un cambio en la medicación del niño, estado de salud o proveedor de cuidado de salud autorizado.
4. Voy a notificar a la enfermera de la escuela, otro supervisor debidamente calificado de la salud, o administrador del sitio inmediatamente y dar su consentimiento para cualquier nuevo cambio en la autorización de proveedor autorizado de atención médica.

☐ **Yo, el padre o tutor del estudiante arriba mencionado, solicito que mi hijo llevar y auto-administrarse su medicación según lo autorizado anteriormente.**

Firma del Padre_____ **Fecha** _____

*** NOTA *** Durante los días de salida temprana y Año Escolar Extendido Programa Especializado de Salud Física procedimientos ordenados a partir del tiempo de despido no se administrará en la escuela. Padre / madre / tutor para proporcionar en el hogar. (Excluyendo "de emergencia " SPHCS).

Reviewed by school nurse (Signature):_____ Date: _____