SCHOOL YEAR 200__ to 200__

Coronado Unified School District

MEDICATION AUTHORIZATION AND PLAN

*All students receiving medication at school require a Medication Authorization and Plan. This authorization may serve as an Individual Health Plan (IHP) for Special Education students or a Section 504 for other students. Prescription and non-prescription medications are permitted at school only when this completed form is on file. If any of the conditions of this authorization change, a new form must be completed and signed by the parent **and** health provider. A fax copy may be accepted until the original can be mailed or brought to the health office. This form is valid for **one** school year and must be renewed annually.*

HEALTH CARE PROVIDER SECTION

_____ has been instructed in the proper use of the following medication(s).
(STUDENT NAME)

In my professional opinion this student **MAY / MAY NOT** carry and use this medication himself / herself. If not, I hereby instruct a designated school staff member to assist this student in taking:

MEDICATION	Dose	Route	Time	Diagnosis/Condition

ASTHMA Peak Flow Zones: Green _____ **Yellow** _____ **Red** _____

Possible side effects while taking this medication: _____

Other medication taken by this student: _____

Emergency plan: _____

_____

Date: ___ / ___ / ___ _____ MD / DO / DDS / DPM / NP / PA
Printed name of provider

_____ _____ _____
CA License # **Signature** of provider Contact number

(For school use) _____ ___ / ___ / ___
Reviewed / approved by school nurse

PARENT SECTION

_____ ___ / ___ / ___ _____ _____
Student Name Birthdate School Grade

I, the undersigned as legal parent / guardian of above student, request a designated member of the school staff make available the above listed medication(s) to my child as prescribed on this authorization and in accordance with California law as referenced below. I also authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed above. I will comply with the procedure listed on the back of this form related to the dispensing and safety of medication at school.

___ / ___ / ___ _____ _____
Date Parent / Guardian Signature Student Signature **(for self** medication)

_____ _____ _____
Home Address Home Phone Work Phone

REFERENCES: *California Education CodeSection:* **49423** Medication at school; **49480** Continuing Medication. *Business and Professional code:* **2725** Verbal Orders; **4033** Definition of a Physician; **4036** Definition of a lawful prescription; **4051** Restrictions on furnishing medications without prescriptions.

(CUSD 07)