American Heritage Charter Schools

MEDICATION AUTHORIZATION AND PLAN

This form is valid only for the 20____- 20____ school year School: _____

According to California Education Code 49423, all students receiving prescription or non-prescription (over-the-counter) medication at school require a Medication Authorization and Plan. Prescription and non-prescription medications are permitted at school **only** when a completed Medication Authorization and Plan is on file at the student's school of record. All medications must be prescribed, including over-the–counter medications. **Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of the Physician. If any conditions of this Authorization change, the parent or guardian must immediately notify the school nurse or site administrator and a new plan must be completed and signed by the parent/legal guardian and the authorized health-care provider.**

PART 1: TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Student's Name: _____ Birthdate: _____ Grade: _____

Parent/Legal Guardian: _____ Teacher: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

As the parent/legal guardian of the above named student, I request that designated school personnel assist my child in taking the following prescribed medication (including prescribed over-the-counter medication). I agree to, and do hereby hold American Heritage Charter Schools and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this medication. I understand that my child may not have nor take medication at school unless all requirements are met. I also give my consent for the school nurse (or designee) to communicate with my child's Physician and counsel school personnel as needed with regard to this medication.

Parent/Legal Guardian Signature: _____ Date: _____

PART 2: TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED HEALTH CARE PROVIDER

I hereby authorize a designated member of the school staff to assist in the administration of the following medication to the above named student as follows:

Medication	Dosage	Method of Administration	Time/Frequency	Diagnosis for which Medication is Prescribed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Side effects that may be experienced: _____

_____

Additional special instructions: _____

If *medical necessity* for child to carry above prescription for *asthma inhaler or medication for emergency situations of anaphylactic shock:*

☐ **Designated school personnel to administer**

☐ **Student is trained and competent to safely self-administer**

Printed Name of Physician: _____ **CA License #** _____

Office Address: _____ **Phone#** _____

Physician's Signature: _____ **Date:** _____