OCEANSIDE UNIFIED • SCHOOL • DISTRICT

PHYSICIAN ORDERS FOR MEDICATION ADMINISTRATION AT SCHOOL

Student Name: _____ Date of birth: _____ Grade: _____

School: _____ Phone #: _____ Fax #: _____

In accordance with California Education Code section. 49423, this form must be completed by a California licensed physician (or other healthcare provider who has the authority to prescribe medication). *De acuerdo con la sección de Código de Educación de California. 49423, esta forma debe ser completada por un médico licenciado en California (u otro proveedor de salud que tiene la autoridad para prescribir medicamento).*

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER

(California licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants - California Code of Regulations, Title 5, section 601[a])

Diagnosis: _____

	Name of Medication	Method of Administration	Dosage	Time to be Given	Frequency
1.					
2.					

Physician's Name (print): _____ **Signature:** _____ **Date:** _____

License No.: _____ **NPI #:** _____ **Office Telephone #:** _____ **Office Fax #:** _____

Upon receipt of medication orders, the School Nurse and the prescribing health care provider shall consult as needed.

1. A current medication form is valid for one CALENDAR YEAR
2. Changes in prescribed dose and other details of medication administration must be provided to the school in writing by the authorized health care provider.
3. All medication must be in the original pharmacy packaging.
4. An adult must bring the medication to the school and pick up any outdated, unused or for home use medication.
5. All medication not picked up by an adult on the last school day will be discarded, unless otherwise arranged.
6. Parents/Guardians must provide all materials or necessary equipment for medication administration.

Cuando recibimos las ordenes para medicamentos, la enfermera y el médico se consultarán cuando sea necesario

1. *Una forma actual de medicamento debe estar en el archivo. Una forma es válida por un año del calendario*
2. *Los cambios en dosis prescrita y otros detalles de administración de medicamentos debe ser proporcionada a la escuela por escrito por el médico autorizado.*
3. *Todos los medicamentos deben estar en el empaque original de la farmacia.*
4. *Un adulto debe traer el medicamento a la escuela y recoger medicamento vencido, que no se ha usado, o medicamento que el estudiante va a utilizar en el hogar.*
5. *Todos los medicamentos no recogidos por un adulto el último día del año escolar serán desechados, a menos que otros planes se han hecho con la escuela.*
6. *Padres/Tutores deben proporcionar todo lo que se necesita para administrar el medicamento.*

I authorize the school nurse, or other designated, trained school staff to administer the medication as directed by the authorized health care provider. I understand that designated staff have my permission to communicate with the prescribing health care provider as related to this medication. *Solicito que la enfermera de escuela, u otro empleado designado por el director/a, administre el medicamento según lo indica el médico.*

Parent/Guardian Signature: _____ **Date:** _____

Registered Credential
School Nurse Signature: _____ **Date:** _____