Solano County Office of Education

AUTHORIZATION FOR MEDICATION REQUIRED DURING SCHOOL HOURS
Individual School Healthcare Plan (ISHP)

This form must be completed with Healthcare Provider and Parent/Guardian signatures before any medication may be taken at school.

California Education code 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day as delegated by the Healthcare Provider. This service is provided to enable the student to remain in school and to maintain or improve the potential for education and learning.
Medications must be given at home if at all possible.

Medication must be in the container in which it was purchased with the pharmacy or manufacturer's label attached and must be prescribed to the student who will be taking the medication. No medications (including over-the-counter medications) will be given at school without a current Healthcare Provider prescription.

Student Name: _____ DOB: _____

Medical Record #: _____ School: _____

==========**Use one form per medication**==

TO BE COMPLETED BY HEALTHCARE PROVIDER:

Nature of condition requiring medication during the regular school day: _____

Medication prescribed: _____

Dosage: _____Time(s) to be administered: _____ Route: _____

Side effects: _____

Signs & symptoms for which a PRN (as needed) medication is to be taken: _____

_____

How soon it can be repeated: _____

Administration of this medication may be delegated to unlicensed assistive personnel in the absence of a licensed nurse unless otherwise indicated.

Healthcare Provider's signature: _____Date: _____

Healthcare Provider's name: _____Phone: _____

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TO BE COMPLETED BY PARENT/GUARDIAN:

My signature below verifies that:

1. I am the parent or legal guardian of the pupil named above.
2. I authorize my child to receive the medication as authorized above.
3. I agree to deliver my child's medication to the appropriate school staff.
4. I agree to hold the Solano County Office of Education harmless from any and all liability resulting from my child taking the medication in the manner directed.
5. I understand that the school nurse may communicate with the appropriate school staff regarding this medication authorization.
6. I give my permission for the exchange of confidential information regarding my child between Solano County Office of Education and the above named healthcare provider as it relates to the above medication.
7. The school will be notified immediately if there is a change in healthcare provider, medication, or instructions.
8. I understand that I need to pick this medication up by the last day of school or it will be discarded.

Parent/Guardian signature: _____ Date: _____

Address: _____ Home phone: _____ Cell phone: _____

 This form must be renewed whenever the prescription changes and at the beginning of each school year.
A completed Medication Self-Administration Form must accompany this form in order for a student to carry and self-administer medication.