

Appleby  
10321 Vernon Ave  
(760)922-7174  
(760)922-0504 F

Margaret White  
610 N. Broadway  
(760)922-5159  
(760)922-1367 F



Ruth Brown  
241 N. Seventh  
(760)922-7164  
(760)922-0636 F

Palo Verde High  
667 N. Lovekin  
(760)922-7148  
(760)922-8916 F

## Administration of Medication and Liability Release

School Year 2024-25

Section 49423 of the California Education Code allows students to take medications prescribed by a physician during the school day, to be assisted by designated school personnel with the medication or to carry and self-administer **CERTAIN** medication when authorized in writing by the student's parent/guardian **AND** physician.

STUDENT NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_  
CURRENT ADDRESS: \_\_\_\_\_ CONTACT NUMBER: \_\_\_\_\_

### PARENT/GUARDIAN AUTHORIZATION (Please refer to back of page for medication requirements)

In accordance with Education Code 49423 sections (a), (b 1, 2 & 3), and (c), 49423.1 sections (a), (b 1, 2 & 3) and (c) and 49407, I, the undersigned parent/guardian of the above named student hereby authorize:

\_\_\_\_\_ A School Nurse, Nurse or designated school personnel to **ASSIST** my child with medication administration, monitoring, and testing according to the physician's instructions and authorization below.

\_\_\_\_\_ **IF APPLICABLE**, my child to **CARRY AND/OR SELF-ADMINISTER**: auto-injectable epinephrine ( ) inhaled asthma medication ( ) according to the physician's instructions and authorization below.

In accordance with California Education Code 49407, I hereby RELEASE, DISCHARGE, AND HOLD HARMLESS the **PALO VERDE SCHOOL DISTRICT**, it's officers, employees and agents from all liability, including injury, death, adverse reactions, or other damages which may arise from the self-administration or assistance with medication administration according to the undersigned parent/guardian and physician described herein.

I agree to provide the medication(s) indicated below in original prescription or manufacturer's containers, which are labeled with the name of the child, the prescribing physician, the medication and dosing instructions. I further authorize the School Nurse or designated school personnel to consult with the prescribing physician should any questions arise, (49480).

I understand that continuous medication requires **ANNUAL AUTHORIZATION** to the school's office at the beginning of each year.

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature

### PHYSICIAN AUTHORIZATION (This section to be completed by the prescribing physician only)

Condition for which medication(s) are being administered: \_\_\_\_\_

NAME OF MEDICATION	DOSAGE	ROUTE	FREQUENCY/TIME
_____	_____	_____	_____
_____	_____	_____	_____

Possible reaction(s) requiring physician notification: \_\_\_\_\_

Storage Requirements: \_\_\_\_\_ START DATE: \_\_\_\_\_ STOP DATE: \_\_\_\_\_

\_\_\_\_\_ I authorize my patient to **CARRY AND/OR SELF-ADMINISTER**: auto injectable epinephrine ( ) inhaled asthma medication ( ) and/or insulin and blood sugar monitor/supplies ( ) according to my instructions and authorization stated herein.

\_\_\_\_\_ I confirm that I have instructed my patient in the procedures, dosing, and timing by which the above medication(s) is/are to be administered and he/she is **COMPETENT** in the self-administration of prescribed medication(s) California Education Code(s) 49423 sections (a), (b 1, 2 & 3) and (c), 49423.1 sections (a), (b 1, 2 & 3) and (c)

\_\_\_\_\_  
Print Physician Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number



## Instructions for Completing the Medication Administration Form

In compliance with Education Code 49423, no medication will be accepted or administered at school without meeting the following requirements. The procedure for administration of medication by prescription and/or non-prescription/over the counter (OTC) medication listed on the medication administration form will be expedited as follows:

1. Only medication prescribed by the student's physician as being necessary to be taken by the student in the manner listed on the medication administration form should be brought to school. The form **MUST BE COMPLETE** and include required parent and prescribing physician signatures.
2. Medication brought to the school to be administered to the student according to the provisions listed on the medication administration form shall be in the **ORIGINAL** prescription or manufacturer's container/packaging, clearly marked with the student's name, the prescribing physician, and the medication name, dose, route, time/frequency and the pharmacy, if physician prescribed.
3. Medications that contain narcotics (some pain and cough relief medications) **WILL NOT** be administered at school.
4. All medications will be stored in a cool, dry and secured place inside the school office. Any special instructions for storage or security measures of any medication should be written by the prescribing physician on the medication administration form.
5. Parent/Guardian or adult 18 years or older shall deliver the medication and the completed administration form to the school office. **DO NOT SEND MEDICATION TO SCHOOL WITH YOUR STUDENT.**
6. Parent/Guardian or adult 18 years or older shall pick up remaining medication during the last week of school. **THE SCHOOL SITE IS NOT RESPONSIBLE FOR MEDICATION LEFT IN THE OFFICE DURING THE SUMMER.**
7. If continuance of medication is necessary, a new medication administration authorization form **MUST** be completed **ANNUALLY** at the beginning of the school year.