KAIROS PUBLIC SCHOOL VACAVILLE ACADEMY

AUTHORIZATION FOR MEDICATION REQUIRED DURING SCHOOL HOURS*

Individual Health and Support Plan (IHSP)

This form must be completed and authorized by the Healthcare Provider and signed by Parent/Guardian before any medications can be taken at school. Failure to complete and return this form will result in the medication being returned. Should students be found with medication in their possession, the student faces disciplinary consequences as outlined in the student handbook.

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. This service is provided to enable the student to remain in school and to maintain or improve the potential for education and learning.

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 medication (including over-the-counter medications, i.e. cough drops/aspirin/Advil) will be given at school without a current physician/dentist prescription.

Student Name: _____ Birthdate: _____ School: _____ Grade: ____

TO BE COMPLETED BY HEALTHCARE PROVIDER: MEDICAL RECORD # _____

Date of student examination: _____ Diagnosis: _____

Medication Prescribed: _____

Dosage: _____ Route: _____

Frequency/Times: _____

USE ONLY ONE FORM PER MEDICATION ORDER

How soon can it be repeated: _____

Side effects/Comments: _____

Treatment of emergency situations: _____

Duration of medication schedule (one year maximum): _____

It is necessary for this medication to be taken during the SCHOOL DAY at the time(s) indicated above.

Healthcare Provider's Signature: _____

Healthcare Provider's Name: _____ Date: _____

Address: _____ Phone: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

My Signature below verifies that:

1. I am the parent or legal guardian of the student named above.
2. I authorize my child to receive the medication as ordered above.
3. I understand that I am to deliver the medication to the school office in a container labeled by the pharmacy with my child's name, name of the medication, and dosage.
4. I give my permission for the exchange of confidential information regarding my child named above between the school district and the above named healthcare provider as it relates to the above medication.
5. I authorize the school nurse or other designated personnel to communicate with appropriate school staff regarding this medication above.
6. I release the school district and school personnel from civil liability resulting from my child taking medication in the manner directed.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Address: _____

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

This form must be renewed whenever the prescription changes and at least once a year.

* A completed "Medication Self-Administration" form must accompany this form in order for a student to carry and self-administer medication.