Silver Valley Unified School District
P.O. Box 847
Yermo, CA 92398

Silver Valley High School
Phone (760)254-2963
Fax (760) 254-3043

Annual Medication Authorization Form / _____

(During School Hours) (Current School Year)

California State Education Code 49423, section 11753.1, states:
"Any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or designated trained personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedule by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physicians statement."

**If there are any special directions that are warranted for the student, please indicate so on the section below; i.e., "student should self-carry or self-administer asthma medication".

PICTURE HERE

Consent to take your child's picture for the safety of dispensing the medication.
_____*Yes* _____*No*
( ) Parent Initials

Name of Student Date of Birth

School Attending Grade Teacher

Name of Medication (Only one medication per form) Expiration Date

Parent Initials ( )

Time To Be Given Amount Of Medication Received

Dosage (Method) *(Any change or modification, and/or change of doctor, at a later date – MUST resubmit a new form)*

Reason For Medication (Symptoms)

Possible Side Effect

Special Directions (Statement by physician; i.e., *Student is capable and may self-administer inhaler.*)

PARENT READ AND SIGN – I give consent for the school nurse to communicate with the authorized health care provider and the pharmacist with regard to the provider's written statement for administration of medication at school. I agree to supply the necessary medication, supplies, and equipment. I may terminate consent for administration at any time. I release the District and school personnel from civil liability if the student suffers an adverse reaction as a result of self-administration. ____*Yes* _____*No*_____ ( ) Parent Initials

FOR SCHOOL USE

Date Received/ Health Clerk Signature

Date Referred / Faxed to Nurse

Date Nurse Reviewed Order / Nurse Signature

Date Assessment for Self-Carry / Nurse Signature

Date Teacher Informed

Physician' Signature Date

Address Phone #

Parent Signature *(Consent for administration of medication by a district employee / Self-administration per physician's order)*

Parent Phone #s home work cell

I authorize the exchange of medical information with staff.
_____Yes ____ No _____
Parent Initials Date

Your child's medication will be kept in the locked medication cabinet for 5 days after school is out. After the 5-day period, all medications will be delivered to the Health Services Department in Yermo and kept locked for duration of 30 days from the last day of school. If medications are not retrieved, they will be disposed of in accordance with the law.

2/1/08 Revised: FILE: Health Manual/Medication Form