

**Vista Unified School District**  
**AUTHORIZATION FOR MEDICATION ADMINISTRATION**  
(Education Code Section 49423)

***This portion to be completed by pupil's school personnel***

Name of pupil \_\_\_\_\_ Birth Date 

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Last First Middle Month Day Year

\_\_\_\_\_  
School Teacher Room Grade

This form is valid only for school year 20 \_\_\_\_ to 20 \_\_\_\_

Location of medication. (Building, room number, cabinet) \_\_\_\_\_

Type of container \_\_\_\_\_

Person(s) authorized to assist pupil (nurse, secretary, self) \_\_\_\_\_

Who is to bring medication to school? (Name of person) \_\_\_\_\_

How often will medication be brought to school? (Daily, weekly, etc.) \_\_\_\_\_

***The front side of this form must be signed by parent before returning to school.***

**• PHYSICIAN'S STATEMENT •**

1. Name of Medication	Method of Administration	Dosage	Approx. time of day
#1 _____	_____	_____	_____
#2 _____	_____	_____	_____

2. Discontinue medication #1 on \_\_\_\_\_ and medication #2 on \_\_\_\_\_  
Date Date

3. Type of assistance for administering medication (Observe, measure, etc.)

4. Precautions for administration or storage of medication

5. Do you wish to have the school personnel contact you at intervals to discuss this medication?  
 Yes  No

Please indicate: Person(s) \_\_\_\_\_ Intervals \_\_\_\_\_  
Teacher, nurse, psychologist, etc. Daily, weekly, quarterly, etc.

\_\_\_\_\_, M. D. \_\_\_\_\_  
Printed name of physician Medical license number Telephone number

\_\_\_\_\_, M. D. \_\_\_\_\_  
Signature of physician Date

VISTA UNIFIED SCHOOL DISTRICT

**AUTHORIZATION FOR MEDICATION ADMINISTRATION**  
(Education Code Section 49423)

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 other designated school personnel if the school district receives:

- 1) A written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken. *See the reverse side of this form.*
- 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 physician's statement. *See authorization statement below.*

This authorization is valid only for the current school year. If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Only medication prescribed by the pupil's physician as being necessary to be taken by the pupil in the manner listed on the Physician's Statement should be brought to school. Medication should be in containers which are clearly marked with the name of the pupil, the name of the prescribing physician, name of the medication, and the amount of medication.

**This portion to be completed by parent/guardian.**

I request that a school nurse or other district designee administer the medication as directed by the physician on the reverse side of this form to my child:

Pupil's Name

I recognize the fact that this is a service or accommodation which the school is not legally required to perform. I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

Signature of Parent/Guardian

Date

Work Telephone Number/Home Telephone Number

DISTRITO ESCOLAR UNIFICADO DE VISTA

**AUTORIZACIÓN PARA ADMINISTRAR MEDICAMENTOS**  
(Sección 49423 del Código de Educación)

Cualquier alumno(a) que necesite tomar, durante el día escolar, un medicamento recetado por un médico para él/ella, puede ser asistido(a) por una enfermera escolar u otro empleado escolar designado si el distrito escolar recibe:

- 1) Una declaración escrita de dicho médico detallando el método, cantidad y horario a seguir para administrar dicho medicamento. *Refiérase a la parte de atrás de este formulario.*
- 2) Una declaración escrita de parte de los padres o tutores del alumno indicando que desean que el distrito escolar asista al alumno(a) a llevar a cabo lo indicado en la declaración médica. *Refiérase a la declaración de autorización a continuación.*

Esta autorización únicamente es válida durante el presente año escolar. Si algunas de las condiciones contenidas en la Declaración Médica cambian, un formulario nuevo debe ser firmado por los padres/tutores y el médico.

Únicamente los medicamentos que el médico le prescribió al alumno que se necesitan administrar al alumno de la manera enumerada en la Declaración Médica deben traerse a la escuela. El medicamento debe estar dentro de un envase que esté identificado con el nombre del alumno, nombre del doctor que prescribe el medicamento, y la cantidad del medicamento.

**Esta parte debe ser llenada por los padres/tutores.**

Yo solicito que una enfermera escolar u otro representante del distrito, le administre a mi hijo(a) el medicamento según las instrucciones del médico, contenidas en la parte de atrás de esta hoja:

Nombre del alumno

Yo reconozco el hecho de que este es un servicio o favor que la escuela no tiene que realizar legalmente. Yo estoy de acuerdo con mantener al distrito, sus oficiales, empleados o agentes, libres de cualquier responsabilidad, demandas o quejas de cualquier naturaleza o especie, que puedan suscitarse como resultado de la administración del medicamento conforme a esta solicitud.

Firma de los padres/tutores

Fecha

Número de teléfono del trabajo/Número de Teléfono de la casa