The Institute for Effective Education

The Institute for Effective Education

Educational Excellence Through Measurably Superior Methods

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

School:	◯ Children's Workshop	◯ COOK Education Center	◯ Mt. Helix Academy	◯ Urban Skills Center
FAX #s	619-521-0432	619-233-8409	619-466-1448	619-233-8409

Name of Student: _____ **Date of Birth:** _____ **School year** _____

Dear Parent/Guardian:

In order to safely administer medications at school, it is necessary to have a written request from parents and a written authorization from a CA licensed physician or a CA licensed dentist.

Please fax or mail completed form to your child's school.

I understand and agree:

- **All medication must be given to the school's office in the original pharmacy container**
- **Medication sent to school in a baggy or other container will be sent home or discarded.**
- **The medication order must match the container**
- **No over-the-counter medications (except Tylenol) are administered unless authorized by a CA licensed physician.**
- **Medications will be administered by school employees who have no medical training**

My child must take medication(s) during the school day (8:30 am to 2:00 pm), and I request that school personnel administer the medication(s) to my child as directed by my child's physician. I agree to save and hold harmless the school, The Institute for Effective Education, its officers, employees, and agents, from all liability or claims of damages, of whatever nature or kind, which might arise as a result of administration or nonadministration of the medication in accord with this request.

I waive my right to privacy concerning the child named above as it pertains to contact between the physician and staff members of The Institute for Effective Education. This authority extends to the furnishing of all or any designated records pertaining to the student named and helps ensure the safe care of your child. This authorization shall be valid ONLY through the current school year. I agree to notify the school immediately if there is a change in medication, health status, or provider.

_____ _____ _____

Parent/Guardian Signature **Print Name** **Date**

TO BE COMPLETED BY MEDICAL CARE PROVIDER

In your authorization, please indicate only medications that should be given during the school day which is from 8:30 am to 2:00 pm. Please avoid liquids if at all possible.

Diagnosis for which the medication is given: _____

MEDICATION/STRENGTH	DOSAGE	ROUTE	TIME OF DAY	START DATE	END DATE

Inhalers: Please weigh the medical necessity of the child carrying the inhaler with the possibility that it may be lost, broken, or misused by the child. Please signify your recommendation by initialing, one of the following:

_____ **The child must have the inhaler with her/him at all times** _____ **The inhaler should be stored in the office**

_____ _____ _____

Printed Name of Physician/Dentist **CA License Number** **Office Telephone**

_____ _____ _____

Signature of Physician/Dentist **Date** **Office Fax #**

(Revised 8/15)