Springs CHARTER SCHOOLS
EMPIRE SPRINGS HARBOR SPRINGS RIVER SPRINGS

MEDICATION AUTHORIZATION RECORD

This form must be completed by physician before any prescription or over-the-counter medications can be staff or self-administered at school. *__New orders__ are required each school year. *For __SEVERE Allergy SEVERE Asthma & Seizure__ please complete an __ACTION PLAN__. *__DIABETICS must__ have a diabetic medical management plan (DMMP) completed by physician.*

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

School: ☐ River Springs Charter School ☐ Empire Springs Charter School ☐ Harbor Springs Charter School
School Phone: _____ **School Fax:** _____

PHYSICIAN USE ONLY

1. **MEDICATION:** _____ Dose: _____ Reason/Symptoms/Diagnosis: _____
   - ☐Oral
   - ☐Inhale Side Effects to Watch for: _____
   - ☐Nasal
   - ☐Topical
   - ☐Other
   - ☐If DAILY = Time(s) to be given: _____
   - ☐If AS NEEDED (prn) ~ Frequency Every_____
   - ☐**Self-Administered** ~ For asthma inhaler or epinephrine auto-injectors ONLY.

For Self-Administered: Student MUST demonstrate competence to self-administer to SCHOOL NURSE
Comments:_____
_____

2. **MEDICATION:** _____ Dose: _____Reason/Symptoms/Diagnosis:_____
   - ☐Oral
   - ☐Inhale Side Effects to Watch for: _____
   - ☐Nasal
   - ☐Topical
   - ☐Other
   - ☐If DAILY = Time(s) to be given: _____
   - ☐If AS NEEDED (prn) ~ Frequency Every _____
   - ☐**Self-Administered** ~ For asthma inhaler or epinephrine auto-injectors ONLY.

For Self-Administer: Student MUST demonstrate competence to self-administer to SCHOOL NURSE
Comments:_____

Physician Signature: _____ Date: _____
Physician Name: _____Phone: _(___)_____
Address: _____

Parent Request for Assistance with Medication at School and Authorization for RSCS Staff to Communicate with Student's Physician

This form must be signed by Parent/Guardian, and be accompanied by **Medication Authorization Form**, before any prescription or over-the-counter medications can be staff or self-administered at school.

Student Name: _____ Date of Birth: _____

School: ☐ River Springs Charter School
☐ Empire Springs Charter School
☐ Harbor Springs Charter School

School Phone: _____
School Fax: _____

California Ed Code Section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for her/him by a physician, may be assisted by the school nurse or other designated person if the school district receives (1) a written statement from the physician detailing the method, amount and time schedules by which the medication should be taken (2) written statement from the parent or guardian indicating the desire that the school district assist the pupil in the matters described in the physician statement. It also states a release of the school district and personnel from civil liability related to any adverse reaction to self-administered medication. **Release of Liability and Agreement to Indemnify and Hold School District Harmless (must be completed)**. I/we hereby expressly release, hold harmless, and agree to indemnify and defend the River Springs Charter School and its Governing Board members, officers , employees, agents, representatives, independent contractors and insurers from all claims and liability for any personal injuries, death, or property damage that may be incurred by permitting the school to assist in the giving my child's medication. This release hold harmless an indemnification agreement shall remain in effect until the written notice to terminate the agreement is received and acknowledged in writing by the school site administrator. I/we understand this agreement and grant the school permission to assist my child with their prescribed medication.

I permit an authorized representative of River Springs Charter School to communicate directly with my child's physician, as may be necessary, regarding any questions that may arise with respect to the medication. I understand that school policies and procedures require that my child's medication be stored in a secure place, under the direction of an adult employee of the River Springs Charter School, and not carried on the person of my child, unless otherwise ordered by physician.

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____ Date: _____

For ASTHMA INHALER/EPI-PENS Self-Administered only. I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that my child must **demonstrate competency to school nurse** and follow the rules and responsibility of carrying his/her medication. I also understand that a student may be subject to disciplinary action if the self-administered medication is used in any manner other than prescribed.

Parent/Guardian Signature: _____ Date: _____

Student Signature:_____ Date: _____

Medication Acceptance Check List

Student Name _____ **Student DOB**_____

☐**Check Medication Authorization Record and Parent Request for Assistance Forms**
☐Student's Name/DOB
☐Medication Name
☐Dosage
☐Route (ie, by mouth, inhaled, topical, nasal)
☐Time, *If as needed, intervals noted
☐ MD Signature/Date/Phone/Fax/Address
☐ Parents Signature and Student Signature if self-administer. Student meet with school nurse to determine student competency to self-administer.

☐**Check Medication Label against the Doctor's Orders/U.S. Pharmacy**
☐Student's name (not grandfather's or sisters)
☐Medication name
☐Dosage
☐Time
☐Expiration Date

DO NOT ACCEPT MEDICATIONS S IF ABOVE AREAS NOT COMPLETE

Count the Medication:

Medication Name: _____	Quantity on Hand: _____ (+) Quantity Received: _____ (-) Quantity Returned: _____ (=) Total: _____

☐ Lock Medication in the Health Office Cabinet or Refrigerator

ParentSignature_____Date_____

Staff Signature_____Date_____