SANTA MONICA – MALIBU UNIFIED SCHOOL DISTRICT
1651 Sixteenth Street, Santa Monica, California, 90404-3891 – (310) 450-8338
Department of Health Services

MEDICATION AUTHORIZATION AND PLAN (___ ISHP / IEP ___504 ___ ISHP ___Episodic)

All students receiving medication at school require a Medication Authorization and Plan. This Authorization serves as an Individual School Healthcare Plan (ISHP) for Special Education students or a Section 504 Accommodation Plan for all other students. Episodic medication refers to medication needed during school hours on a temporary basis for episodic illnesses. Prescription and non-prescription medications are permitted at school only when a completed Medication Authorization and Plan is on file. If any of the conditions of this Authorization change, a new form must be completed and signed by the parent/ guardian and health care provider. A new Medication Authorization and Plan form must also be filled out for each new school year.

This form is valid for school year _____ to _____.

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Parent Section:

I, the undersigned as legal parent / guardian of _____ (student's name) _____ (student's birth date), request a designated member of the school staff make available the following listed medication(s) to my child as prescribed on this authorization and in accordance with California law as referenced below. I also authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed below. I will comply with district rules related to dispensing medication at school.

_____ _____ _____

Date Parent / Guardian Signature Parent / Guardian printed name

_____ _____ _____

Home address City zip Work phone Home phone

* *

Provider Section:

I hereby instruct a designated school staff member to assist the above student in taking:

Medication Dose Route Time Diagnosis/Condition

_____

_____

_____

Side effects that may be experienced even if given as prescribed: _____

_____

Other medication taken by this student: _____

_____

EMERGENCY PLAN: _____

_____

I have instructed this student in the proper use of the above listed medication (s). In my professional opinion _____MAY / MAY NOT (circle which) carry this medication him / herself.

_____ _____

Printed name of provider Title Telephone #

_____ _____ _____

Signature of provider CA license # Date

References: *California Education Code* Section: 49423 Medication at School; 49480 Continuing Medication. *Business and Professional Code: 2725* Verbal Orders; definition of a Physician; 4036 definition of a lawful prescription; Restrictions on furnishing medications without prescription