

# Travis Unified School District

## AUTHORIZATION FOR MEDICATION REQUIRED DURING SCHOOL HOURS\* Individualized Health and Support Plan (IHSP)

**This form must be completed and authorized by the Healthcare Provider and signed by Parent/Guardian before any medication can be taken at school.**

California Education Code 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain or improve the potential for education and learning.

Medication must be in the container in which it was purchased with the pharmacy or manufacturer's label attached and must be prescribed to the student who will be taking the medication. No medication (including over-the-counter medications including cough drops/aspirin/advil) will be given at school without a current physician/dentist prescription.

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ School: \_\_\_\_\_ Gr. \_\_\_\_\_

**TO BE COMPLETED BY HEALTHCARE PROVIDER: MEDICAL RECORD # \_\_\_\_\_**

**USE ONLY ONE  
FORM PER  
MEDICATION  
ORDER**

Date of student examination: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Medication Prescribed: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Frequency/Times: \_\_\_\_\_

How soon can it be repeated: \_\_\_\_\_

Signs & symptoms for which a PRN (as needed) medication is to be taken: \_\_\_\_\_

Side effects/comments: \_\_\_\_\_

Treatment of emergency situations: \_\_\_\_\_

Duration of medication schedule (one year maximum): \_\_\_\_\_

It is necessary for this medication to be taken during the **SCHOOL DAY** at the time(s) indicated above.

Healthcare Provider's signature: \_\_\_\_\_

Healthcare Provider's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Print)

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### **TO BE COMPLETED BY PARENT/GUARDIAN:**

My signature below verifies that:

1. I am the parent or legal guardian of the student named hereon.
2. I authorize my child to receive the medication as ordered above.
3. I understand that I am to deliver the medication to the school office in a container labeled by the pharmacy with my child's name, name of the medication and dosage.
4. I give my permission for the exchange of confidential information regarding my child named above between the school district and the above named healthcare provider as it relates to the above medication.
5. I authorize the school's health services to communicate with appropriate school staff regarding this medication order.
6. I release the school district and school personnel from civil liability resulting from the student taking medication in the manner directed.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Address: \_\_\_\_\_  
(Print)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**This form must be renewed whenever the prescription changes and at the beginning of the school year**

\*A completed "Medication Self-Administration" form is needed in order for a student to carry and self administer medication.