

**Murrieta Valley Unified School District**  
**AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIBED**  
**MEDICATION AT SCHOOLS**  
**WITHIN THE COUNTY OF RIVERSIDE**

Name of Student	Date of Birth	Grade	School
<p><b>Education Code 49423.</b> Any pupil who is required to take, during the regular school day, medication prescribed for him or her by a physician and surgeon or ordered for him or her by a physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, may be assisted by the school nurse or other designated school personnel or may carry and self-administer prescription auto-injectable epinephrine if the school district receives the appropriate written statements identified in subdivision (b).</p> <p><b>Education Code 49423.1</b> In order for a pupil to carry and self-administer prescription inhaled asthma medication pursuant to subdivision (a), the school district shall obtain both a written statement from the physician or surgeon detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken, and confirming that the pupil is able to self-administer inhaled asthma medication, and a written statement from the parent, foster parent, or guardian of the pupil consenting to the self-administration, providing a release for the school nurse or other designated school personnel to consult with the health care provider of the pupil regarding any questions that may arise with regard to the medication, and releasing the school district and school personnel from civil liability if the self-administering pupil suffers an adverse reaction by taking medication pursuant to this section.</p>			

**Physician Authorization**  
**ONE MEDICATION PER FORM**

Name of Medication	Health Condition for which medicine RX
Time(s) to be taken	Dosage
Method of administration	Precaution-Possible untoward reactions
Date to be discontinued	Physician's Telephone Number (     )
Name of Physician (Please Print)	Physician's Fax Number (     )
Physician's Signature	Date
<p>The above mentioned student must carry this medication on his/her person. The student has demonstrated knowledge of the correct dosage and administration and is sufficiently responsible to carry out my directions as instructed. In addition, he/she is responsible to notify the school health office whenever he/she takes the drug if monitoring and record keeping is required per parent and physician.</p> <p>The principal or designee reserves the right to revoke the privilege if the student demonstrates irresponsible behavior or incorrect inhaler administration.</p>	

I request that my student be allowed to carry and self-administer their prescribed emergency medication and agree to hold Murrieta Valley Unified School District, it's officers or employees harmless from all liability or claims which might arise out of these arrangements. I give my permission to contact the physician for consultation as needed. I understand that all medication will be destroyed at the end of the school year unless other arrangements are made and it is picked up by a parent or designee.

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Date

Please return this from to your child's school health office signed by the physician and the parent or guardian.

**THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR  
 OR WHENEVER THERE IS A CHANGE IN MEDICATION OR INSTRUCTIONS.**