FRIENDSHIP SCHOOL
San Diego County Office of Education
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san diego county office of EDUCATION
FUTURE WITHOUT BOUNDARIES™

AUTHORIZATION FOR MEDICATION ADMINISTRATION IN EMERGENCY/DISASTER ONLY

THIS AUTHORIZATION IS TO BE USED ONLY IN CASE OF EXTREME EMERGENCY/DISASTER
AND THE PUPIL IS REQUIRED TO REMAIN AT THE SCHOOL BEYOND NORMAL SCHOOL HOURS
FOR SAFETY OR UNTIL THE PARENT/GUARDIAN CAN PICK THEM UP.

In the event of an emergency, the school nurse or other designated school district personnel is to give the following medication(s) to: ______________________________ at the times and in the amounts
student's name birth date
listed below:

Medication	Dosage	Amount	Expiration Date

I,______________________________, the parent/guardian have provided 72 hours worth of medication to be kept locked at the school for emergency use. Each type of medication is in its original container, labeled with the student's name, dosage, amount to give, what times to give and any expiration date for medication.

I realize that it is my responsibility to provide the school with an updated authorization form and change in medication(s) any time the doctor changes the student's medication.

I request designated school personnel to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, the parent/guardian must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the health care providers allowed by HIPAA.

Signature of Parent/Guardian **Date** **Phone Number**

The above named child is on the medication listed. The dosage, amounts given, and time given are as stated above.

Physician Signature **NPI #** **Date** **Phone Number**