Los Gatos-Saratoga
UNION HIGH SCHOOL DISTRICT

Governing Board
Cynthia Chang
David Guidry
Peter L. Hertan
Rosemary Rossi
Katherine Tseng
Superintendent
Michael Grove, Ed.D.

Authorization to Carry Medication

In accordance with California Education Code section 49423, this form must be completed by an authorized California healthcare provider and be on file for any student who is required to carry medication for emergency use of

Epinephrine Auto Injectors, **Asthma Rescue Medications**, **OR** to carry equipment/medication for **Diabetic Care.**

Student Information:

Last Name	*First Name*	*DOB*	*Grade*

School Name	*School Phone number*	*School Fax*	*School Nurse (if applicable*

TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER:
(California licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants - California Code of Regulations, Title 5, section 601[a])

DRUG:_____DOSE:_____AMOUNT:_____.30_____TIME:_____PRN

ROUTE:_____

OBSERVABLE ADVERSE REACTIONS THAT MIGHT BE SEEN AT SCHOOL:

_____

Student has severe allergy to :_____ **Asthma Triggers:_____**

Student is authorized to carry, and is able to self-administer *prescription for* ***Severe Allergies, asthma*** *or* ***diabetes care.*** *(Authorized licensed healthcare provider initials: _____).*

Student is authorized to carry, and is able to self-administer auto-injectable **epinephrine** independently and to carry Benadryl _____ mg to self-administer.
(authorized licensed healthcare provider initials: _____).

Authorized Healthcare Provider Name (print) **Signature** **Date**

License Number Phone Number **Fax Number**

I authorize my child to carry the above named medication for emergency use or Diabetic Management. He/she has been properly trained in the use of the named medication.

Parent/Guardian Name (print) **Signature** **Daytime Phone Number** **Date**

Reviewed by Credentialed School Nurse (print) **Signature** **Date**