



Dear Parents,

The Newhall School District recognizes that your child may need medication during regular school hours, and we are prepared to assist in that need. We are guided by the California Education Code, Section 49423, which outlines how medications are to be administered during school hours. The requirements for any medication taken during school hours are as follows:

1. A Newhall School District Medication Permission Form must be completed and signed by the physician and parent or guardian, detailing the amount, method, and time schedule the specified medication is to be taken.
2. Each medication is to be in the original container, clearly labeled with the student's full name, the physician's name and phone number, the name of the medication, dosage, schedule, and date of expiration of the prescription.
3. Students are not permitted to use any medications during school hours, except when administered by a parent, or a school employee under the conditions described in this letter. The parent or legal guardian is responsible for delivering medications to the school office and picking up medications from the school office. Under California law, students may carry their own asthma inhaler and/or epi-pen with the appropriate authorization. Contact the District Nurse for authorization forms.
4. Any change in long-term medication (dosage/time/drug) must be immediately reported to the school. The medication permission form must be updated by parent and physician. Parents/guardians who elect to discontinue medication prescribed in the school setting must provide the school with written and signed notice or an order from the prescribing physician. They must immediately pick up the medication from the school office.
5. Whenever possible, parents are encouraged to enlist the physician's cooperation to work out a schedule which will eliminate the necessity of administering medication at school.
6. Medication authorizations must be renewed for each school year.

Please note: Students are not permitted to carry any medications with them (in their backpack, pockets, etc.) unless the medication has been authorized by the Physician, Parent, and District Nurse. This includes, but is not limited to Tylenol, Motrin, Cold Pills, Cough Drops, Herbal Preparations, and Vitamins. If your child needs these medications during school hours, please follow the procedure above, or a parent of the child can come to the school to administer the medication.

This policy was established to protect your child and to avoid the sharing of medication among children. **NO EXCEPTIONS WILL BE MADE.** Thank you for your cooperation. Please direct any further questions to the Newhall School District Nurses at (661) 291-4184.

DISTRITO ESCOLAR NEWHALL
AUTORIZACIÓN PARA DISPENSAR MEDICINAS RECETADAS POR UN DOCTOR

Estimados padres de familia o tutores,

El Distrito Escolar Newhall quiere ayudarles a ustedes, a su médico y a su niño(a) con la medicina recetada por su médico. Para poder dispensar el medicamento a su hijo(a) en la escuela, deberán entregar este formulario con **su firma** y la **firma del médico**. Después de firmar este formulario, **llévenlo a su médico y pídanle que también lo firme.***

Autorizo a los empleados del Distrito Escolar Newhall a suministrar a mi hijo(a) la medicina recetada por mi médico de acuerdo al Artículo 49423 del Código de Educación de California. Si esta autorización es para continuar suministrando una medicina que ya se administra diariamente en la escuela, esta autorización se mantendrá en vigencia hasta el último día del año escolar presente y será necesario renovarla el próximo año.

Nombre del alumno(a) **Fecha de nacimiento** **Firma del padre/ Fecha**
Al completar este formulario, usted autoriza al Distrito Escolar Newhall ponerse en contacto con el médico de su hijo(a) para hacerle preguntas acerca de la dispensa de los medicamentos mencionados en la parte de abajo.

NO SE ADMINISTRARÁ EN LA ESCUELA NINGUN MEDICAMENTO RECETADO POR SU MEDICO SIN TENER ESTA AUTORIZACIÓN FIRMADA APROPIADAMENTE.

ATENCIÓN MÉDICOS:

Los medicamentos de la lista siguiente son recetados para _____ (nombre del niño), que tomará durante las horas de escuela (8:30 a.m. – 3:00 p.m.) Por favor describa la dosis exacta y la hora exacta.

Nombre(s) del medicamento(s)	Dosis	Hora(s)

Posibles efectos secundarios: _____ Sueño _____ Mareo _____ Pérdida de equilibrio
 _____ Irritabilidad _____ Dolor de cabeza _____ Dolor de estómago
 _____ Nausea/vómito _____ Fotosensibilidad _____ Diarrea
 _____ Otro

Este medicamento es recetado a partir de (fechas) _____ hasta _____.

NOTA: El medicamento dado en el hogar podría también modificar el comportamiento de aprendizaje. Por lo tanto, nosotros solicitamos información respecto a cualquier medicamento recetado por el doctor dado en el hogar.

La lista de medicamentos de la lista siguiente es recetada para que este niño la tome solamente antes de las 8:30 a.m. o después de las 3:00 p.m.

Medicamento: _____ Propósito: _____
 Fecha de inicio: _____ Fecha final: _____
***Firma del doctor:** _____ No. de teléfono del doctor. _____
 Domicilio del doctor: _____
 NPI# _____