

## Instructions for Completing Medication Authorization Form

**Any child who takes medication, vitamins, and/or supplements must have a completed Medication Authorization Form signed by an authorized licensed California health care provider** (CA licensed physician, surgeon, nurse practitioner, nurse midwife, dentist, optometrist, podiatrist, physician assistant – CA Code of Regulations, Title S, Section 601[a]). International medications, including those from Mexico, or authorizations from Mexican physicians are not allowed by law.

If your child takes any of the following, a completed and signed Medication Authorization Form is required, otherwise it cannot legally be administered by Cuyamaca Outdoor School staff:

- **Routine prescription medication** including pills, liquids, inhalants, and injections
- **Emergency prescription medications** (e.g., inhaler, epinephrine auto-injector, Valtoco, Baqsimi, etc.)
- **Vitamins**
- **Supplements, including melatonin, fiber, herbal, homeopathic, etc.**
- **Routine non-prescription/over-the-counter medications not listed on the back of the Student Registration and Health Form**

### All prescription medications must:

- Be sent in the original container labeled by a California pharmacist and may not be expired
- Be labeled with the child's full name (cannot be another family member's medication)
- List the exact dosage, form (pill, liquid, etc.), time (when it should be given), route (how it is taken), and reason (what is the medication for)
- List the prescribing authorized licensed California health care provider

### All non-prescription medications, vitamins, and supplements must:

- Be sent in the original, store-bought container that lists the name, dosage, and instructions
- Be labeled with the child's full name and school (write on the container or use tape or a label)

***We cannot accept or administer anything sent in a plastic baggie, pill box, pill reminder container, unlabeled container, etc. DO NOT send any medications, vitamins, or supplements in your child's luggage.***

### STEPS TO COMPLETE THE MEDICATION AUTHORIZATION FORM:

1. Fill in the top of the form with:
  - a. Child's school
  - b. Dates of attendance at Cuyamaca Outdoor School
  - c. Child's last name
  - d. Child's first name
  - e. Child's date of birth (DOB)
2. SECTIONS A, B and C must be completed by an authorized licensed California health care provider (CA licensed physician, surgeon, nurse practitioner, nurse midwife, dentist, optometrist, podiatrist, physician assistant – CA Code of Regulations, Title S, Section 601[a]) for any daily/routine medications, vitamins, and supplements. The authorized licensed health care provider must sign the form.
3. SECTION E must be completed and signed by the student's parent/legal guardian.
4. SECTION D and all other sections in **GRAY** are for Cuyamaca Outdoor School use only.
5. Give the completed and signed Medication Authorization Form along with your child's medication to your child's school at least **three weeks** before your child attends outdoor school.

**If you have any questions, please contact your child's school nurse or call the Cuyamaca Outdoor School Health Center at 760-765-4110. Thank you, and we look forward to your child's visit!**



## Medication Authorization Form

**ORDER FOR ADMINISTRATION OF MEDICATION AT CUYAMACA OUTDOOR SCHOOL.** All medication/s, vitamins, and supplements must be sent in the original container.

**SECTIONS A-C** must be completed and signed by an authorized licensed California health care provider (CA licensed physician, surgeon, nurse practitioner, nurse midwife, dentist, optometrist, podiatrist, physician assistant – CA Code of Regulations, Title S, Section 601[a]) **for any daily/routine medications, vitamins, and supplements.**

**SECTION E** must be completed and signed by the student's parent/legal guardian. **SECTION D** and all sections in GRAY are for Cuyamaca Outdoor School use only.

Student's School \_\_\_\_\_

Dates of Attendance \_\_\_\_\_

Cabin
HG

Student's Last Name \_\_\_\_\_

Student's First Name \_\_\_\_\_

DOB \_\_\_\_\_

SECTION A: To be completed by Health Care Provider	SECTION D: Cuyamaca Outdoor School Use Only
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Med #	Medication/Vitamin/Supplement Details <i>(include generic name of medication)</i>	✓ IN by:	Mon		Tues		Wed			Thurs			Fri		✓ OUT by:	
			Mid	PM	AM	Mid	PM	AM	Mid	PM	AM	Mid	PM	AM		Mid
1	Medication/Dose (mg):															
	Form / Time:															
	Route / Reason:															
	Count IN:      Count OUT:															
2	Medication/Dose (mg):															
	Form / Time:															
	Route / Reason:															
	Count IN:      Count OUT:															
3	Medication/Dose (mg):															
	Form / Time:															
	Route / Reason:															
	Count IN:      Count OUT:															
4	Medication/Dose (mg):															
	Form / Time:															
	Route / Reason:															
	Count IN:      Count OUT:															

**SECTION B: Additional Instructions**  
(attach a care plan if needed):

**SECTION C: To Be Completed by Health Care Provider**

Health Care Provider _____	
CA License # _____	
Phone # _____	
Signature _____	Date: _____
<i>COS Initials &amp; Signature:</i> _____	<i>COS Initials &amp; Signature:</i> _____

**SECTION E: To Be Completed by Parent/Legal Guardian**

I authorize Cuyamaca Outdoor School to administer the medication/s, supplements, and/ or vitamins listed above to my child as directed by the authorized licensed health care provider.	
Parent/Legal Guardian _____	
Phone # _____	
Signature _____	Date: _____
<i>COS Initials &amp; Signature:</i> _____	<i>COS Initials &amp; Signature:</i> _____