SCHOOL MEDICATION AUTHORIZATION FORM

Name of Child ___________________________ Date of birth: ______________________

School ___________________ Phone: _______________ FAX # ___________________

California Ed Code 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school or maintain or improve the potential for education and learning.

Medication must be in the container in which it was purchased with a pharmacy label attached. No medication (including over-the-counter medication and supplements) will be given at school without a current prescription from a California licensed physician.

PHYSICIAN’S ORDER (To be completed by health care provider) Only one medication per form

Name of medication/strength of tablet, capsule or liquid _______________________________

This medication is a controlled substance ☐ Yes ☐ No

Dosage: ___________________________ How Often? ___________________________

Time to be given at school: __________________ Route to be given: __________________

Reason for medication/Diagnosis: _____________________________________________

Possible side effects: _________________________________________________________

☐ Student has been instructed by physician in self-administration and may carry the inhaler with them

☐ Student has been instructed by physician in self-administration and may carry the Epi-Pen with them

Comments _________________________________________________________________

__________________________________________
Print Name of Licensed Physician

__________________________________________
Signature of Licensed Physician

Address ___________________________ Phone __________________ Date __________________ License # _______________

***********************************************************

TO BE COMPLETED BY PARENT BEFORE GIVING FORM TO DOCTOR

I request that my child, ___________________________________________ , be assisted in taking the above prescribed medication at school by authorized persons. I will comply with the school’s policies and procedures. I will notify the school if there are changes in my child’s health status, changes in medication or change in health care provider.

I authorize exchange of information between my child’s Physician, District Nurse, or site administrator with regard to this medication request.

__________________________________________
Parent/Guardian Signature

__________________________________________
Date

__________________________________________
Phone (home)

__________________________________________
Phone (emergency)

Name of medication to be given at school ___________________________ Time to be given at school _________

Form must be renewed every 12 months or whenever the prescription changes.

dh 8/15/2006