

**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 \_\_\_\_\_

*It is necessary for this medication to be taken during the school day at the time(s) indicated above.*

Print Name of Licensed Physician \_\_\_\_\_ Signature of Licensed Physician \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ License # \_\_\_\_\_

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**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.*