Parent/Physician Authorization for the Administration of Medication at School

This form must be completed with M.D./Dentist and Parent/Guardian signatures before any medication can be administered at school.

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

Medication must be in the container in which it was purchased with the pharmacy label attached, and must be prescribed to the student to whom it will be administered. No medications, including over-the-counter medications will be given without current M.D., Dentist or other authorized healthcare professional prescription.

Student Name:_____Date:_____

School of Attendance:_____

To Be Completed By Health Care Provider:

Date Student Examined:_____Diagnosis:_____

Medication Prescribed:_____

Dosage:_____Time:_____Route:_____

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Medication administered until: _____

It is necessary for this medication to be taken during the school day at the time(s) indicated above and may be administered by medically untrained personnel.

Permission to Carry Inhaler or Other Life-Saving Medication at School: or

Epinephrine Auto-Injectors (Food or Bee sting allergies)

The student above has been instructed in the proper use of (inhaler/life-saving medication). The child's well-being is in jeopardy unless the inhaler/medication is carried on his/her person: therefore we request that he/she be permitted to carry the inhaler/medication. He/she understands the purpose, appropriate method, and frequency use of this inhaler/mediation and that sharing medication with other students will result in disciplinary action.

Physician's Signature_____Date:_____

Physician's Name:_____Phone:_____

To Be Completed By Parent/Guardian:

Please Initial Appropriate Lines.

_____ I authorize school personnel to administer the above medication to my child as ordered by the health care provider.

_____ I give permission for my child to self administer the above medication

_____ I give my child permission to carry his/her inhaler/life-saving medication.

_____ I give permission for my child to carry on Epinephrine auto-injector.

Parent/Guardian Signature: _____

Home Address: _____

Phone Number:_____Date:_____

This Form Must Be Renewed Whenever The Prescription Changes and At The Beginning of Each School Year.