Print Form

AUTHORIZATION TO ADMINISTER MEDICATION

STUDENT MEDICATION Legal Reference: Education Code Section 49423
"...any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated school personnel if the school district received (1) written statement from such physician detailing the name of the medication, the method, amount and time schedules by which such medication is to be taken, and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement." No other medication is to be administered by school personnel. This includes all medication available without prescription.

Medication is to be sent in a container labeled with the student's name, name of prescribing physician, name of medication, and instructions. Please complete and include this form.

Student _____ Grade _____ Teacher _____ Date _____

Parent _____ Phone _____

Health Care Provider _____ Phone _____

1.

Medication(s)	Dose	Frequency	Duration	Possible Side Effects

2. Additional information and/or precautions regarding medication or student's conditions:

_____

3. Authorization for Self-administration of Medication:
Is student authorized to self-administer these medications while at school? ◯ Yes ◯ No

If yes, please complete the following contract:

A. Student: I certify that I have read and understand the instructions regarding the self-administration of my medication(s). I agree to take these above described medications in compliance with my health care provider's recommendation.
Student Signature _____ Date _____

B. Parent/Guardian: _____ (Student) has been instructed in the proper dosage and administration of the following medication(s) _____
We/I, (parent/guardian) request that s/he be permitted to carry this medication on his/her person and self-administer it as directed by our physician and in compliance with District policy and procedures.

Parent/Guardian Signature _____ Date _____

4. I am the parent/guardian of the above student and have lawful custody of said child. I hereby give consent to appropriate District personnel to administer or assist in administering medication and/or treatment as specified by his/her health provider. Furthermore, I hereby give consent to the District to receive from or send to the health care provider any information concerning my child's medical condition. Please note: It is the parent's responsibility to see that this form is updated as needed.

Parent/Guardian Signature _____ Date _____

5. Health Care Provider: I am a physician actively licensed by the State of California. Attached hereto is a prescription for the medication/treatment specified above.

Physician Signature _____ Date _____