MEDICATION AUTHORIZATION FORM

Name of child: _____ Date of birth: _____

School _____ Grade: _____Phone: (530) 241-3261 FAX#: (530) 241-5139

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 original container. No medication (including over-the-counter medication and supplements) will be given at school without a current "School Medication Authorization Form" completed by a health care provider licensed in California to prescribe medications.

PHYSICIAN'S ORDER *(TO BE COMPLETED BY HEALTH CARE PROVIDER) ONLY ONE MEDICATION PER FORM*

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

Dosage: _____ How Often? _____

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

Reason for medication/Diagnosis: _____

Possible side effects: _____

☐ Student has been instructed in self-administration of Epi-Pen and is competent to carry and safely self-administer
☐ Student has been instructed in self-administration of inhaler and is competent to carry and safely self-administer

For PRN medication only, please list specific symptoms that would necessitate administration of the PRN med:
_____

Regarding the PRN medication, please give instruction for when a medical referral is to be made:
_____

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

_____ _____
Print Name of Licensed Provider Signature of Licensed Provider

_____ _____ _____
Address Phone Date

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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 Medical Provider, 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.