AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Last Name	First Name	Middle Initial	Date of Birth: month/day/year

Name of School	School's Fax Number	Teacher's Name & Room Number	Grade

In accordance with California Education Code section 49423, all students receiving medication at school require a medication authorization which must be must be completed by a California licensed physician or other healthcare provider who has the authority to prescribe medication in the state of California. The information requested on this form is necessary to comply with the law and to insure adequate protection for students. If any of the conditions on this authorization change, a new form must be completed and signed by the parent and health care provider. **This form valid for school year _____to _____.**

PARENT SECTION

I, the undersigned as legal parent/guardian of _____ _____ (student's name) _____(birth date) authorize the school nurse, or other school staff designated by the school site principal, to administer the following listed medication(s) to my child as prescribed on this authorization and in accordance with California law as referenced below. I also authorize, as needed, the sharing of information related to my child's health on matters related to this medication, between the school nurse (or designee) and the health care provider listed below. I will comply with the procedures listed on the back of this form related to administering medication at school.

Date: month/day/year	Parent/Guardian Signature	Daytime Phone Number

PROVIDER SECTION: To be completed by an authorized health care provider

Diagnosis/Condition _____

I hereby instruct a designated school staff member to assist the above student in taking:

Medication	Dose	Method of Administration	Time to be given	Frequency
1				
2.				

Discontinue Medication # 1 (date) _____ Discontinue Medication # 2 (date)_____

Other medications taken by this student:_____

Health Care Provider's Name (printed)_____ Signature_____

MD/DO/DDS/PA/NP CA License # _____

Supervising Physician's Name/address/Phone # (if applies) _____

Reviewed by (Name of School Nurse)	Signature	Date