# MEDICATION AUTHORIZATION FORM

Child's name:_____DOB:_____

School:_____Grade:_____Date:_____

California Education Code 49423 provides for any pupil who takes medications (prescribed or over-the-counter) during the regular school day and/or overnight field trips to have the following:

1. A written statement from the physician detailing the method, amount, and time schedule the medication is to be taken.
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.

**Medication must be in the original container (prescription and over-the-counter medications). The medication should be clearly labeled with the student's name, medication name, & dosage and must be stored in the school health office.**

**To be completed by physician:**

Medication:_____ Dosage:_____

Time:_____ ☐ Before Lunch_____ ☐ After Lunch_____

☐ As Needed for the following symptoms:_____

**Students may carry the below list of medications at school with doctor and parent authorization. Please mark if applicable.**

| | | | | |
|---|---|---|---|---|
| A. | Inhaler | ☐ Keep in office | ☐ Carry with him/her | ☐ May self-administer |
| B. | EpiPen | ☐ Keep in office | ☐ Carry with him/her | ☐ May self-administer |
| C. | Diabetic Supplies | ☐ Keep in office | ☐ Carry with him/her | ☐ May self-administer |

**The school should be aware of the following side effects**_____

_____

_____ _____

**Print Name of Physician/Provider** **Date**

_____ _____

**Signature of Physician/Provider** **Phone Number/Fax Number**

I understand that this consent may be terminated at any time.

**By signing this form I authorize the following:**

- I hereby give permission for the designated school personnel to administer the above medication to my child
- **I authorize the nurse to communicate with the physician**
- I authorize my child to self-administer the medication described above, A, B or C, and release civil liability if student suffers adverse reaction

_____ _____

**Parent Signature** **Date**