SANTA CLARA UNIFIED SCHOOL DISTRICT
MEDICATION AUTHORIZATION FORM

In accordance with *California Education Code Section 49423*, this form must be completed by a California licensed physician or other health care provider who has the authority to prescribe medication and be on file for any student who requires medication (prescription or over-the-counter) during the regular school day. Written permission from the student's parent or legal guardian is also required.

Student _____ DOB _____

School _____ Grade _____ Teacher _____

TO BE COMPLETED BY PHYSICIAN

1) MEDICATION _____ DOSE _____

TIME/FREQUENCY _____ ROUTE _____

REASON FOR MEDICATION _____

Medication will continue for _____ days or until _____

Observable adverse reactions that might be seen at school: _____

2) MEDICATION _____ DOSE _____

TIME/FREQUENCY _____ ROUTE _____

REASON FOR MEDICATION _____

Medication will continue for _____ days or until _____

Observable adverse reactions that might be seen at school: _____

Physician signature _____ Date _____

Physician name (stamp or print) _____ Phone _____

Address: _____ Fax _____

PARENT INFORMATION

- Please provide medication in its original and properly labeled container to school office. Prescription medication must be in the pharmacy-labeled container with the student's name clearly visible.
- Please inform school of any changes in the medication plan along with new orders.
- Medication forms must be renewed annually.

I authorize school staff to assist with medication administration as directed by the authorized health care provider.

Parent/guardian signature* _____ Date _____

**Signature authorizes communication between the school nurse and prescribing provider regarding the prescribed medication or over-the-counter product, if necessary.*

Revised 02/2013