OLD ADOBE UNION SCHOOL DISTRICT - SCHOOL HEALTH SERVICES
AUTHORIZATION TO ADMINISTER MEDICATION

Student's Name_____ Date of Birth_____Grade_____
School_____ School year_____
The California Education Code 49423 provides for any pupil who is required to take, during a regular school day, medication that is prescribed for him/her by a physician, and may be assisted by the school nurse or designated school personnel if the school district has received the following:

1. Medication must be provided in the **ORIGINAL CONTAINERS (both prescription and over the counter)** and labeled with student's name, medication name, dosage and **EXPIRATION MUST BE CURRENT.**
2. A written statement from the physician detailing the method, amount and time schedule the medication is to be taken, purpose of the medication, signed by the physician.
3. A written statement from the parent or guardian of the student indicating the desire that the school district assist the student in the matter set forth in the physician's statement, signed by the parent or guardian.

Non-Prescription Medications

The health office keeps the following medications in stock. All other non-prescription medications must be provided by parent in original container and labeled with child's name. **This form requires a physician's signature, even for over-the-counter medications.** Please authorize medication administration by checking appropriate boxes or filling in *Other OTC Medication.*

Children's Tylenol	Adult Tylenol	Tums	Claritan	Tecnu	Dramamine
Children's Motrin	Adult Motrin	Pepto Bismol	Zyrtec	Caladryl	Meclizine
Children's Benadryl	Adult Benadryl	Imodium	Cough Drops	Hydrocortisone 1% cream	

These OTC medications or their generic are dispensed per package directions unless written directives are provided by a physician here:_____

Other OTC medications and Prescription Medications

Diagnosis:_____Medication:_____

Dosage:_____ Method of Administration:_____

As needed Before lunch After lunch Scheduled at _____o'clock

Please mark if applicable:

A. Inhaler	Keep in office	Student may carry with him/her and self-administer
B. Epi Pen	Keep in office	Student may carry with him/her and self-administer
C. Diabetic Supplies	Keep in office	Student may carry with him/her and self-administer

Possible side effects:_____
Expiration of order:_____
Physician's Signature_____ Physican's **STAMP**:
Physician's Printed Name_____
Physician's Phone Number_____

To be completed by the parent or guardian:

- 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 in A,B or C and release civil liability if student suffers adverse reaction.

Parent Signature _____ Date_____
Parent's Printed Name_____ Parent's Phone Number_____