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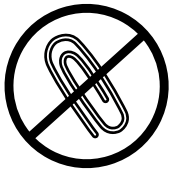
PLEASE DO NOT WRITE ABOVE THIS LINE - FOR MAGNUS HEALTH USE ONLY

Magnus Health

MEDICATION AUTHORIZATION FORM

This coversheet is **ONLY** for the form and student listed above
and **MUST BE RECEIVED** for processing.

DO NOT use staples or paperclips!



Please print and complete this form then
submit all pages including this coversheet via:

FAX		MAIL
(877) 447-9530 Outside of the United States? Please fax to (978) 244-8894	-OR-	**Magnus Health Does Not Accept Mailed Forms**

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 nay 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: **Almaden Country Day School** Grade_____

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:_____
3) MEDICATION_____ DOSE_____ TIME/FREQUENCY_____ ROUTE_____ REASON FOR MEDICATION_____ Medication will continue for _____ days or until _____ Observable adverse reactions that might be seen at school:_____

4) 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_____
Physican Name_____	Phone_____

PARENT INFORMATION

- Please provide medication in its original and properly labeled container to school offiice. Prescription medication must be in the pharmacy-labeled container with the student's name clearly visable.
- 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