



NORWALK - LA MIRADA UNIFIED SCHOOL DISTRICT

12820 Pioneer Blvd., Norwalk, CA 90650-2894 (562) 210-2415

<b>OFFICE USE</b>
Nurse Reviewed: _____
Date: _____

PHYSICIANS AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL DURING THE REGULAR SCHOOL DAY

<b>TO BE COMPLETED BY PARENT:</b>					Grade: _____
Student Last Name	First	D.O.B.	School	Student ID#	
<p>The above named student is required to take medication prescribed by a physician during the regular school day, which cannot be taken any other time. I request that designated school personnel assist my child in taking the medication in accordance with the instructions provided below by the physician. I authorize the district to communicate with the physician below regarding my child's medical condition and or the medication prescribed for it. I am responsible for bringing the medication and any necessary supplies. I understand medication must be in original pharmacy labeled container clearly stating prescription information. I will be responsible for picking up any left over medication at the end of the school year.</p> <p>In signing this form, the parent/guardian agrees to release from liability the District, its officers, employees, or agents for any loss, damage, injury, or liability of any kind to any person caused or arising from the acts, omissions, or negligence of the District, its officers, employees, or agents related to the administration of medication to their child.</p>					
Date	Telephone	Signature of Parent or Guardian			

<b>TO BE COMPLETED BY A LICENSED PHYSICIAN: ONE MEDICATION PER FORM.</b>		
<i>(Note: Rx label must match medication order)</i>		
Purpose of Medication	Name of Medication	Dose Form (Tablet, liquid, etc)
Dosage Prescribed	Time Schedule at School	If PRN, include conditions
Precise Method of Administering Medication: _____		
Length of Time this Medication will be Necessary: _____ Current school year or Short duration until _____ (date)		
<b>Describe precautions, special instructions, possible adverse reaction, or other comments.</b> <b>(PLEASE INCLUDE STORAGE INSTRUCTIONS):</b>		
The Above Named Student, For Whom This Medication is Prescribed, is under my care.		
Print Name of Physician	Signature of Physician / Date	
Address	Telephone	

**THIS REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR IN WHICH MADE AND MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR AND WHENEVER THERE IS ANY CHANGE IN THE MEDICATION.**

**The California Education Code (49423):**

**ADMINISTRATION OF PRESCRIBED MEDICATION FOR PUPIL** Notwithstanding the provision Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

**RECORDING MEDICATIONS RECEIVED:** Record the date and amounts of medication received and sign your name. This must be done each time medication is brought to school.

DATE MEDICATION RECEIVED	AMOUNT	EXPIRATION DATE	SIGNATURE OF PERSON RECEIVING MEDICATION

**RECORDING MEDICATIONS DISPENSED:** Write your initials over the date that you administer the medication. Leave the dates blank if medication was not given. Write your initials and signature in the KEY area.

August	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
September	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
October	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
November	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
December	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
January	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
February	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
March	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
April	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
May	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
June	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
July	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

**KEY:**

Initial \_\_\_\_\_ Signature \_\_\_\_\_ Date Medication began \_\_\_\_\_ Initial \_\_\_\_\_  
 Initial \_\_\_\_\_ Signature \_\_\_\_\_ Date Discontinued \_\_\_\_\_ Initial \_\_\_\_\_  
 Initial \_\_\_\_\_ Signature \_\_\_\_\_ Date Medication Returned: \_\_\_\_\_  
 Initial \_\_\_\_\_ Signature \_\_\_\_\_ Picked up by (signature): \_\_\_\_\_

[ ] Medication **not picked up** at end of the school year. Medication collected for disposal.  
 Date Collected: \_\_\_\_\_ Staff Initials: \_\_\_\_\_  
 If controlled substance: Count \_\_\_\_\_ / Witness: \_\_\_\_\_