THE KING'S ACADEMY

GRADE_____

Medication at School Authorization Form 2026-2027

One Authorization Form is required for EACH specific medication*

PARENT/GUARDIAN: Before ***ANY*** medication can be taken during school hours, it is necessary to have specific written orders from your student's physician as well as written authorization from you.

MEDICATIONS: Students are **not** allowed to carry medications, whether prescribed or "over the counter," unless accompanied by ***BOTH*** a physician's note and a parent/guardian's note stating that the student is allowed to self-administer the medication. All other medications on campus must be kept in the SAO with both physician and parent/guardian notes as per California Education Code (CEC 49423), Title 5. Staff members, including the School Nurse, are not allowed to give out painkillers, antihistamines, or the like, without proper authorization. **Medication must be in the original pharmacy labeled container with the student's name clearly visible.** Any over the counter medication must be in its original container as well.

Student LEGAL Name: _____ Gender: ____ Date of Birth: _____
Last First

_____
Physician's Name Address Phone

I request that my student be assisted in taking the medication described below at school by authorized persons, or to be permitted to medicate him/herself as authorized by me and my student's physician (see below). I **MUST** notify TKA immediately of any changes or alterations to the prescription, including discontinued use.

_____
Date Legal Parent/Guardian Signature Emergency Phone Number

PHYSICIAN: *Please complete the following section.*

Diagnosis for which medication is given: _____

Name of medication and dosage: _____

Dose: _____

If medicine to be given DAILY, at what time: _____

If medicine to be given AS NEEDED, describe indications: _____

_____

How soon can it be repeated? _____

Is the student authorized to medicate himself/herself? ☐ Yes ☐ No

Is this medication to be carried by the student on his/her person? ☐ Yes ☐ No

List significant side effects: _____

Other information: _____

Length of time this treatment is recommended: _____

Physician's Signature: _____ **Date:** _____