PRESCRIPTION AND OVER THE COUNTER MEDICATION AUTHORIZATION

FOR HEALTH CARE PROVIDER APPROVAL

For allergy, asthma and seizure medication, please use the appropriate condition form

Student Name: _____ **DOB**_____

California Education Codes 49423 and 49480 permit administration of medication(s) by designated school personnel. Medication must be provided in original container labeled with the student's name, medication name, dose/strength, expiration date, & specific administration directions.

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Parent/Guardian Authorization

As the parent/guardian of the above named student, I request that designated school personnel assist in the administration of medication prescribed by the physician. I understand it is my responsibility to bring all medication safely to the school and I agree to refill or replace medication as necessary. I will notify the school immediately if there are changes in name, dose, route or time of medication administration. I understand that medication will be stored in a secure area unless the physician indicates below that my child is capable of carrying and self-administering it. I give consent for the physician and designated school personnel to communicate directly regarding the administration of medication.

Parent/Guardian Name: _____ **Phone:** _____

Signature: _____ **Date:** _____

Student Statement (only if authorized to self-carry medication):
I understand that I am allowed to carry and self-administer only the medication(s) listed. I agree to use the medication as instructed by my physician and not to share with other people. I understand that if I share the medication with others, I will be held accountable for my actions and that I will face disciplinary action.

Student Signature:_____ **Date:** _____

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Physician/Prescriber Authorization

TO BE FILLED OUT BY PHYSICIAN

Diagnosis/ Reason for Medication_____

Adverse Reactions: _____

Name of Medication	Form: pill, cream, inhaler etc.	Dose/ Number to be taken	Time given Or PRN	PRN Reason	**PHYSICIAN INITIAL** if student may self carry and administer

Prescriber's Signature: _____ **Date:**_____

Discontinuation Date (one year unless specified) _____

Physician/Clinic Stamp **REQUIRED:**