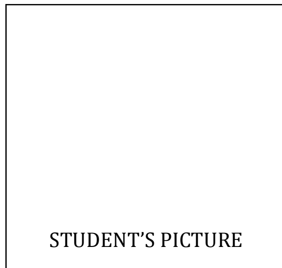

PHYSICIAN'S AUTHORIZATION FOR PRESCRIPTION & NON PRESCRIPTION MEDICATION DURING THE SCHOOL DAY: PRN/DAILY MEDICATIONS

(NOT USED FOR ANAPHYLAXIS) (Ed Code Section 49423)

______________________________________ Student's Name ______________ DOB: mth/day/yr

______________________ ______________________ School Name ________ Teacher

Grade

In accordance with California Education code section 49423, this form must be completed by a California licensed physician (or other healthcare provider who has the authority to prescribe medication in CA) and be on file for any student who requires medication(s) during the regular school day.

THIS SECTION TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER: I hereby instruct a designated school staff member to assist student in taking.

A. Medical Diagnosis/Condition **Symptoms To Be Treated**

1. ______________________________ ______________________________
2. ______________________________ ______________________________

B. Name of Medication **Method of Administration** **Dosage** **Time to be Given** **Frequency**

1. ____________ ____________ ________ ________ ________
2. ____________ ____________ ________ ________ ________

C. Side effects that may be experienced even if given as prescribed ______________________________

____

D. Discontinue Medication #1 (date) ______________ Discontinue Medication #2 (date) ______________

Health Care Provider's Name (print): ______________________ **Signature:** ______________________

CA License #: ______________ **Phone:** ______________ **Fax:** ______________ **Date:** ______________

★ I have instructed this student in the proper use of asthma inhalant medication. In my professional opinion, this student **MAY**________ or **MAY NOT** ________ carry & use medication him/herself. (Must be initialed by Physician)

This Section to be completed by Parent/Guardian

I will comply with the procedure listed on this form related to dispensing medication at school designated.

1. A current medication form must be on file. **A new form must be on file each school year for each medication.**
2. If any of the conditions in the Physician's Authorization change, a new form must be signed by the parent/guardian and the physician.
3. All medication must be in a container labeled by a pharmacist or prescribing health care provider. Which clearly identifies the name of the pupil, the name of the prescribing physician, name of medication and the amount of the medication to be given.
4. An adult must bring the medication to the school and pick up any outdated, unused or for home use medication.
5. All medication not picked up by an adult on the last school day will be discarded, unless otherwise arranged.
6. Parents/Guardians must provide all materials or necessary equipment for medication administration.

★ I authorize the school nurse, or other school staff to administer the medication as directed by the authorized health care provider. I understand that designated school staff has my permission to communicate with the prescribing physician/health care provider on matters related to this medication.

★ I recognize the fact that this is a service or accommodation, which the school is not legally required to perform. I agree to save and hold the district, it's officers, employees or agents, harmless from all liability suits or claims, or whatever nature of kind, which might arise as a result of administering the medication in accord with this request.

______________________ ______________________ ______________ ______________

Parent/Guardian Signature | Signature of Student (Self Medication) | Phone # | Date