School year:________________

This request if valid for a maximum of one school year!

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: ______________________________________Birthdate: __________________________

Address: ____

School/ Organization:____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION OF NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school/program day. This service is provided to enable the student to remain in school/program and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical childcare personnel may assist in carrying out written orders. I will notify the school and/or Community Care Club immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school and/or Community Care Club representative to exchange medication-related information with the authorized health care provider. The school and/or Community Care Club representative may counsel appropriate childcare personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: _____________________________________Date: _______________________________________

Telephone: (Work/Cell) ____(Home)____________________________________

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: ____

Medication: ________________________________ Dose:___________________________Route: ____________ Time:_______

If PRN: Amount of time between doses ________________________________Maximum # of doses ________________ per day

Possible medication reactions: ____

Instructions for emergency care ____

Authorized Health Care Provider Signature: ____

Authorized Health Care Provider Name (print clearly):____

Telephone: ____Date of Request: ____

Date to Discontinue Medication: ________________________________Med Expiration Date: ____________________________

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self-administer this emergency Inhaler/EpiPen. This student has been instructed, and demonstrates and understanding of proper usage.

SCHOOL USE ONLY:

Reviewed by:____Date:_____________________________