

## MEDICATION REQUIRED DURING SCHOOL HOURS

California Education Code Section 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. Medication must be in the container in which it was purchased, with the pharmacy label attached, and must be prescribed to the student to whom it will be administered. No medications, including over-the-counter medicine, will be given without current Physician/Podiatrist/Dentist authorization. This service is provided to enable the student to remain in school to maintain or improve the potential for education and learning.

STUDENT'S NAME:(print) \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

SCHOOL OF ATTENDANCE: \_\_\_\_\_

---

### To be completed by Physician/Podiatrist/Dentist/Medical Care Provider

*In my professional opinion, this student **MAY**  or **MAY NOT**  carry and use this medication him/herself.*

Date patient examined \_\_\_\_\_ Diagnosis \_\_\_\_\_

Medication Prescribed \_\_\_\_\_

\*Dose \_\_\_\_\_ Time/Interval \_\_\_\_\_ Route \_\_\_\_\_

\*DO NOT GIVE RANGE; BE DOSE SPECIFIC

Administer until (date) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name (PRINT) \_\_\_\_\_ Phone \_\_\_\_\_

FAX # \_\_\_\_\_

Physician's Office Stamp (REQUIRED) \_\_\_\_\_

---

### To be completed by Parent/Guardian

I authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider. My child **MAY**  or **MAY NOT**  carry and use this medication him/herself (physician must agree).

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_, \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_

THIS FORM MUST BE RENEWED WHENEVER THE PRESCRIPTION CHANGES **AND** AT THE BEGINNING OF EACH SCHOOL YEAR.

Nurse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Principal's Signature \_\_\_\_\_ Date \_\_\_\_\_