



**PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION**

Name of Student: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
School/ District: \_\_\_\_\_ Teachers Name: \_\_\_\_\_ Grade/Track \_\_\_\_\_

**PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION  
PRESCRIPTION AND NON PESCRIPTION**

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 day. This service is provided to enable the student to remain in school 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 instruction. I understand that designated non-medical school personnel will administer medication under supervision of a qualified School Nurse. I will notify the school 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 nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel Appropriate school personnel regarding the medication and its possible effects.

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

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

Telephone: (Work) \_\_\_\_\_ (Home) \_\_\_\_\_

**AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MECICATION**

Reason for Medication: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

If PRN: Amount of time between doses \_\_\_\_\_ Maximum number of doses \_\_\_\_\_ per day.

Possible medication reactions: \_\_\_\_\_

Instructions for emergency care \_\_\_\_\_

Authorized Health Care Provider: \_\_\_\_\_

Telephone \_\_\_\_\_

Date of Request: \_\_\_\_\_

Office Stamp

Date to Discontinue Medication: \_\_\_\_\_

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

Health Care Provider Initials \_\_\_\_\_

**SCHOOL USE**

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_