



**PARENT/GUARDIAN AND PHYSICIAN REQUEST FOR MEDICATION**

Name of Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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

California Education Code Section, 49423 allows the 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 instructions. I understand that designated non-medical school personnel may assist in carrying out written orders. 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 health staff to exchange medication-related information with the authorized health care provider. The health staff may counsel appropriate school personnel regarding the medication and its possible effects.

Back-up medication should be kept at school for emergency use. I release OCHS 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) \_\_\_\_\_ (Home) \_\_\_\_\_

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

Reason for Medication/Physical Condition: \_\_\_\_\_

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**

Signature: \_\_\_\_\_

Name (print clearly): \_\_\_\_\_

Telephone \_\_\_\_\_

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

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

**Office Stamp**



**AGENCY USE:**

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

This request is valid for a maximum of one year. Follow-up by this date: \_\_\_\_\_