

## PARENT/GUARDIAN AND PHYSICIAN REQUEST FOR MEDICATION

Name of Student:		Birthdate:		
PARENT/GUARDIAN REQU PRESCRI	JEST FOR THE AD		EDICATION	
California Education Code Section, 49423 allows required to take medication during the school d to maintain, or improve his/her potential for education	s the designated no ay. This service is p	on-medical school person provided to enable the st		
I request that medication be administered to my instructions. I understand that designated non-rotify the school immediately and submit a new and/or the prescribing authorized health care prelated information with the authorized health or regarding the medication and its possible effects	medical school per oform if there are of rovider. I give pern care provider. The	sonnel may assist in carry changes in medication, d nission for the health sta	ying out written orders osage, time of adminis ff to exchange medicat	i. I will tration, ion-
Back-up medication should be kept at school for my child suffers an adverse reaction as a result of			l personnel from civil li	ability if
Parent/Guardian Signature:		Date:		
Telephone: (Work)		(Home)		
AUTHORIZED HEALTH CARE PROV	VIDER REQUEST	FOR ADMINISTRATION	OF MEDICATION	
Medical Condition/Diagnosis:				
Medication:	Dose:	Route:	Time:	
If PRN: Amount of time between doses	Maximι	um number of doses	per day.	
Possible medication reactions:				
Instructions for emergency care				
Authorized Health Care Provider				
Signature:	Nan	ne (print clearly):		
	Offic	ce Stamp		
Telephone				
Date of Request:				
Date to Discontinue Medication:				
AGENCY USE:				
Reviewed by:		D	ate:	
This reaues	t is valid for a max	ximum of one year.		