CHICO UNIFIED SCHOOL DISTRICT
1163 E. 7th Street, Chico, CA 95928

SCHOOL: _____ **PHONE:** _____ **FAX:**_____

Authorization To Administer Medication

School Year _____

Legal Reference: Education Code Section 49423 "…any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated school person, if the school district received:

1) A written statement from such a physician detailing the name of the medication, the method, amount, and time schedules by which such medication is to be taken, and

2) A written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matter set for in the physician's statement."

No other medication is to be administered by school personnel.
This includes all medication available without a prescription.

Student Name:	**Date of Birth:**	**Teacher:**
Parent/Guardian:	**Phone Parent/Guardian:**	**Work Phone Parent/Guardian:**
Health Care Provider:	**Phone of Health Care Provider:**	**Fax of Health Care Provider:**

Medication is to be sent in the *original container* labeled with the *name of the student*, *name of prescribing physician*, *name of medication* and *instructions*. This form must be completed and included. It is the parent's responsibility to update this form as needed.

Medication(s)	***Method of Administration***	***Dose / Concentration***	***Time of Day***

Additional Information and/or Precautions regarding medications or student's condition:

HEALTH CARE PROVIDER: I am a physician actively licensed by the state of California. **Attached is a prescription for the medication/treatment specified above. ( ) Initial here if student has been properly trained and is able to self-administer.**

Physician Signature _____ **Date** _____

I am the parent/guardian of the above student and I have lawful custody of said child. I hereby give consent to designated school personnel to administer or assist in administering medication(s) and/or treatment as specified by his/her health care provider. Furthermore, I hereby give consent to the School to receive from, or send to, the health care provider any information concerning my child's medical condition.

Parent/Guardian Signature _____ **Date** _____

Complete this section for medications which student may ***self-administer***:

AUTHORIZATION FOR SELF-ADMINISTRATION:

Student: I certify that I have read and understand the instructions regarding the self-administration of my medication(s). I agree to take these above described medication(s) in compliance with my health care provider's recommendations.

Student Signature _____ **Date** _____

Parent/Guardian: My child has been instructed in the proper dosage and administration of the above medication and has demonstrated the ability to self-administer. We/I (Parent/Guardian) request that she/he be permitted to self-administer it as directed by our healthcare provider's compliance with District policy and procedures.

Parent/Guardian Signature _____ **Date** _____

PLEASE RETURN THIS FORM TO THE HEALTH OFFICE AT CHILD'S SCHOOL