CHICO UNIFIED SCHOOL DISRICT
1163 E. 7th St., Chico, CA 95928

PHYSICIAN'S RECOMMENDATIONS FOR MEDICATION DURING THE SCHOOL DAY

Student's Last Name	First Name	Middle Initial	DOB: month/day/year	Grade

Name of School	School Phone #	School Fax #	School Nurse

In accordance with California Education Code section. 49423, this form must be completed by a California licensed physician (or other healthcare provider who has the authority to prescribe medication) and be on file for any student who requires medication(s) during the regular school day.

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER
(California licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants - California Code of Regulations, Title 5, section 601[a])

A. Nature of condition requiring medication during the regular school day

_____

B.

Medication	**Administration/Method**	**Dosage**	**Time to be given**	**Frequency**

☐ **I give student permission to carry/self-administer the above emergency medication, inhaler, or epinephrine auto-injector.**

Health Care Provider's Name (print): _____ **Signature:** _____

License No. _____ **Phone No:** _____ **Fax No.** _____ **Date:** _____

C. Upon receipt of medication orders, the school nurse and the prescribing health care provider shall consult as needed.
1. A current medication form must be on file. **Form expires one year from date signed.**
2. Changes in prescribed dose and other details of medication administration must be provided to the school in writing by the authorized health care provider.
3. All medication must be in a container labeled by a pharmacist. If OTC medication, must be in original container.
4. An adult must bring the medication to the school and pick up any outdated, unused or for home use medication.
5. All medication not picked up by an adult on the last school day will be discarded, unless otherwise arranged.
6. Parents/Guardians must provide all materials or necessary equipment for medication administration.

I authorize the school nurse, or school personnel trained by the school nurse, to administer the medication as directed by the authorized health care provider. I understand that designated school staff has my permission to communicate with the prescribing physician/health care provider on matters related to this medication.

Parent/Guardian's Signature	Daytime Phone Number	Month/Day/Year

Reviewed by (Name of School Nurse)	School Nurse's Signature	Month/Day/Year