SUTTER UNION HIGH SCHOOL DISTRICT
2665 Acacia, P. O. Box 498, Sutter, CA 95982

AUTHORIZATION FOR MEDICATION TO BE GIVEN AT SCHOOL

Pupil Name _____ Birthdate _____ School Year _____

Dear Parent/Care Provider:

California Education Code, Section 49423 provides that any pupil required to take medication during regular school days, may be assisted by the school nurse or designated school personnel. ALL MEDICATIONS WHETHER PRESCRIPTION OR NON-PRESCRIPTION REQUIRE DOCTOR AND PATENT AUTHORIZATION, AND MUST BE IN THEIR ORIGINAL CONTAINERS AND CURRENT PRESCRIPTION BOTTLES.

1

Medication to be administered _____

Dosage: _____ How Often: _____

Time of Day: _____ Duration: _____

Anticipated reactions to medicaiton: _____

2

Medication to be administered _____

Dosage: _____ How Often: _____

Time of Day: _____ Duration: _____

Anticipated reactions to medication: _____

The proper use and risk of carrying an INHALER or EPIPEN on the school premises will be the responsibility and liability of the student and parent.

☐ **PHYSICIAN**: Check box if you feel it is medically necessary for the student to carry the above prescribed INHALER or EPIPEN with him/her during school hours.

Educational observations of children on medication will be made when necessary. If you desire to receive these reports, please contact the school.

X _____ _____ _____ _____

Physician's Signature | Date | Physician's Printed Name | Telephone

I approve of this authorization for medication to be given to my child by school personnel.

X _____ _____ _____ _____

Parent/Care Provider Signature | Date | Home Phone | Work Phone

PARENT'S AUTHORIZATION FOR EXCHANGE OF INFORMATION

I hereby give my permission for the exchange of information regarding my child's medication:

_____ _____

Student Name | Birthdate

between: _____ and Sutter Union High School District staff.

Name of Physician

X _____ _____

Signature of Parent/Guardian | Date

Please return this form to Sutter Union High School.

MEDICATION ADMINISTRATION LOG

Student Name: _____ **Year:** _____

Medication: _____ **Doctor:** _____ **Dosage:** _____ **Time:** _____

Directions: _____

School personnel assisting student with medication is to initial the appropriate date space.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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