LIVE OAK UNIFIED SCHOOL DISTRICT
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This authorization is valid only for the current school year ________________ including the summer session.

School: ____

To meet the requirements of Education Code 49423, this form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse will call the physician, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Physician's Authorization

Name of Student: ______________________________ Date of Birth: ________________________ Grade: __________

Condition for which medication is being administered: ____

Medication Name: ________________________________ Dose: ____________________ Route: ________________

Time/frequency of administration: ____

Relevant side effects: □ None expected □ Specify: ____

Medication shall be administered from: ____________________ to ____________________
Month / Day / Year Month / Day / Year

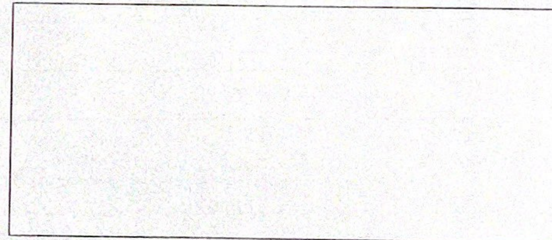
Physicain's Name/Title: ______________________________
(Type or print)

Telephone: ____________________ FAX: ____________________

Address: ____

____

Physician's Signature: ____________________ Date: __________
(Original signature or signature stamp ONLY)



(Use for Physician's Address Stamp)

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to assist in the administration of the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: ____ Date: ________________

Home Phone #: ____________________ Cell Phone #: ____________________ Work Phone #: ____________________

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

In rare instances because of a life threatening condition, self-carry/self-administration of emergency medication may be authorized by the physician and must be approved by the school nurse.

*Physician's authorization for self-carry/self-administration of emergency medication: ______________________
Signature/ Date

*School nurse approval for self-carry/self-administration of emergency medication: ______________________
Signature/ Date

Authorization Form reviewed by the school nurse: ____
Signature/ Date

Updated Aug. 2011