SCVUSD # 35 MEDICATION AUTHORIZATION FORM

THIS 2 PAGE FORM MUST BE RETURNED TO THE HEALTH OFFICE WHEN PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS ARE REQUIRED FOR THE STUDENT

Note for Parents/Guardians and Physicians:

District personnel are not permitted to give medication of any kind (prescription and non-prescription) unless the parent or guardian authorizes, in writing, that the student requires the medication. The parent or guardian's authorization MUST be accompanied by written physician authorization for prescription and non-prescription medication.

Medication must be delivered to the school with the label intact. The container housing the medication must be clearly labeled by the physician or pharmacy with the following information: student's name, date of birth, physician's name, name of medication, reason for the administration, dosage, schedule (dates/times), route and date of expiration must also be printed clearly on the label. Non-prescription medication must be in the original container and be labeled clearly with the dosage appropriate for the student's age and weight.

Name of Student: _____ Date of Birth: _____

School:_____ Grade: _____

I consent to the administration of the medication indicated by the Physician to the student while at school. I also understand that I am responsible for maintaining an adequate supply of the medication at the school to meet the student's needs.

_____ _____
Signature of Parent/Guardian Date

_____ _____ _____
PRINTED name of Parent/Guardian Primary contact phone Work phone

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For prescription and non-prescription medication, THE PHYSICIAN MUST COMPLETE THE FOLLOWING INFORMATION:

Student: _____ **DOB**: _____

* Medication: _____

* Strength of Medication: _____

* Dosage (amount to be given): _____

* Frequency/Time: _____

* Expiration/Discontinuation date: _____

* Reason Medication Prescribed: _____

* Precautions: _____

* Possible adverse reactions: _____

* Contradiction with any other medications or food: _____

* Emergency Treatment: _____

_____ _____

Signature of Physician Date

_____ _____ _____

PRINTED name of Physician Office Phone Fax