CHICO COUNTRY DAY SCHOOL
102 W. 11th Street, Chico CA 95926
(530) 895-2650 FAX (530) 895-2646

MEDICATION AUTHORIZATION FOR 2021-22 SCHOOL YEAR

_____ _____ _____ _____ _____
Student's Last Name First Name Middle Date of Birth Grade

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])

Nature of condition requiring medication during the regular school day:
_____

Medication	Administration/Method	Dosage	Time to be Given	Frequency

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

License No. _____ Phone # _____ FAX # _____ Date _____

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 at the end of current school year.**
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 An adult must bring the medication to the school and pick up any outdated, unused or for home use medication.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 by the last day of school will be discarded.
6. Parents/Guardians must provide all materials or necessary equipment for medication administration.

☐ **I give student permission to carry/self-administer the above emergency medication, inhaler, or epinephrine auto-injector and release school from civil liability if self-administration results in an adverse reaction.**

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

Please discontinue administering _____ on _____.
Name of Medication Date

Parent Name _____ Parent Signature _____