



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

**MEDICATION AUTHORIZATION FOR 2022-2023 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 An adult must bring the medication to the school and pick up any outdated, unused or for home use medication.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** \_\_\_\_\_