Paradise Unified School District, 6696 Clark Rd, Paradise, CA 95969

		FAX			FAX
___ Cedarwood Elementary:	873.3785	873.1017	___ Paradise Intermediate:	872.6465	876.1852
___ Paradise Elementary:	872.6415	872.6419	___ Paradise High School:	872.6425	872.6427
___ Pine Ridge Elementary:	873.3800	873.2828	___ Ridgeview High School:	872.6478	872.6481
___ Ponderosa Elementary:	872.6470	872.6474	___ District Office:	872.6400	872.6409

AUTHORIZATION FOR MEDICATION TO BE GIVEN AT SCHOOL

Dear Parent/Guardian:

California Education Code, Section 49423, provides that any student required to take, during regular school days, medications prescribed by a physician may be assisted by the school nurse or other designated school personnel if the school district receives specified written statements from such physician and the parent/guardian of the student.

Student Name: _____ Birth date: _____

PHYSICIAN'S AUTHORIZATION to give medication at school **(to be completed by the physician)**:

1) Medication and Strength:_____
   Amount of medication (number or capsules, tablets, ml.) _____
   Time of day to be given: _____
   Purpose of medication: _____
   Possible side-effects: _____
   ☐ Check box if you (physician), approve it is medically necessary for the student (6th through 12th grade) to carry the above prescribed INHALER/EPIPEN with him/her during school hours, and you (physician) have observed and approved the student's techniques of self-administration.
2) Medication and Strength:_____
   Amount of medication (number or capsules, tablets, ml.) _____
   Time of day to be given: _____
   Purpose of Medication: _____
   Possible side-effects: _____
   ☐ Check box if you (physician), approve it is medically necessary for the student (6th through 12th grade) to carry the above prescribed INHALER/EPIPEN with him/her during school hours, and you (physician) have observed and approved the student's techniques of self-administration.

I hereby authorize school personnel to administer the above medication(s) as directed.

Physician's signature: _____ Date: _____

_____

Physician's PRINTED Name Phone FAX #

Physician's Address: _____

PARENT'S AUTHORIZATION for exchange of information & administration of medication at school (**to be completed by parent/guardian**)

1) I approve of this authorization for medication to be given to my child by school personnel as indicated by my child's physician on this medication form.
2) I also give my permission for the exchange of information contained in the record of my child between the above-named doctor and Paradise Unified School District.
3) I also give my consent to the self-administration if approved by physician and release the district and school personnel from civil liability if the student suffers adverse reaction as a result of self-administering the medication.

Parent/Guardian Signature: _____ Date: _____

_____

Parent/Guardian PRINTED NAME Home Phone / Cell Phone / Work Phone / Fax #

- Authorization for Medication Form *MUST* be signed by parent/guardian *AND* physician before any medication is given by school personnel. Parent/guardian are responsible for providing medication. **DO NOT SEND MEDICATION WITH THE STUDENT TO SCHOOL.**
- Medication must be brought to the school by the parent/guardian unless another method of delivery is authorized by Superintendent or designee. (ALTERNATIVE DELIVERY: _____ Authorized by: _____)
- ALL medication must be in ORIGINAL and CURRENT PRESCRIPTION BOTTLE.
- Authorizations for medication in school must be completed each year for long term medications.
- This form is valid for CURRENT school year only and must be renewed each school year.

School Nurse (Printed Name & Signature Date