SAN LUIS OBISPO COUNTY
OFFICE OF EDUCATION
LEADERSHIP • COMMUNITY • SERVICE

APPROVAL TO ADMINISTER MEDICATION

To the Parents/Guardians:

If medication must be taken during the school day, it is necessary, according to California Education Code Section 49423, to receive a written statement from the parent or guardian of the pupil indicating that the school nurse or other designated school personnel assist the pupil with the medication as prescribed by his or her physician.

State law requires ANY prescription or over-the-counter medications must have a complete statement from BOTH the doctor and the parent BEFORE they can be dispensed. Medicine must be in the prescription bottle labeled with the correct name and dosage. Over-the-counter medication must be in the original container. Schools are not allowed to dispense individual or separate medication without this information.

Student's name: _____ DOB: _____ School: _____

Address: _____ Telephone No: _____

Physician's name: _____ Telephone No: _____

Address: _____ Fax No: _____

I request that designated school personnel assist my child with his/her medication, as prescribed by the above named physician, at school. I authorize the physician to release medical information concerning the administration of this medication to the school nurse. I release the San Luis Obispo County Office of Education from any liability or responsibility if my child has adverse effects from this medication. I understand that sharing medication with other students will result in disciplinary action.

Parent/Guardian signature: _____ Date: _____

Printed name: _____

To the Physician:

If medication must be taken during the school day, it is necessary, according to California Education Code section 49423, to secure a written statement from the pupil's physician detailing the method, amount, and time schedules by which such medication is to be taken. Please complete the information below for the above named student.

Name of medication: _____ Route given: _____

Dosage: _____ Time schedule: _____

Side effects to look for: _____ Reason ordered: _____

*If the above named medication is an inhaler or other rescue medication: The student understands the purpose, appropriate method, and frequency of use. It is my opinion that he/she can safely and competently carry and self-administer the inhaler, epi pen or other rescue medication named above: **Y**_____**N**_____

Physician's signature: _____ Date: _____

Printed name: _____

PLEASE RETURN FORM TO PARENT OR FAX TO SCHOOL NURSE AT (805) 546-0646