PALERMO UNION SCHOOL DISTRICT

SCHOOL MEDICATION AUTHORIZATION FORM

Re: California Ed Code Section 49423 (see back of form)

TO BE COMPLETED BY PARENT BEFORE GIVING FORM TO DOCTOR

I request that my child, _____, date of birth _____, be assisted in taking this prescribed medication at school. I will comply with the school's policies and procedures. I agree to, and do hereby hold the school and its employees harmless from any and all claims, demands, causes of action, liability or loss of any sort because of, or arising out of, the acts or omissions of the school or its employees with respect to this medication.

_____ _____ _____

Parent Signature Date Phone (home)

_____ _____

Address City Zip Phone (emergency)

Please list any/all allergies_____

PHYSICIAN'S ORDER: *(To be completed by the physician only)*

Name of medication / strength: _____

Dosage: _____ How often/duration? _____

Time to be given at school: _____ Dose form: _____
(Tablet/liquid)

Reason for medication: _____

Possible side effects: _____

☐ Student has been instructed by physician in the use of inhaler and may carry with them.
☐ Student has been instructed in the use of the EPI-PEN and may carry medication with them.

Comments: _____

The pupil for whom this medication is prescribed is under my care.

_____ _____

Print Name of Licensed Physician Signature of Licensed Physician

_____ _____ _____

Address Phone Date