Miller Creek School District
380 Nova Albion Way San Rafael, CA 94903
Phone: 415.492.9700
Fax: 415.492.3707

AUTHORIZATION TO ADMINISTER MEDICATION FORM

STUDENT MEDICATION Legal Reference: Education Code Section 49423 *" ...any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) written statement from such physician detailing the name of the medication, the method, amount and time schedules by which such medication is to be taken, and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement." This applies to "over-the-counter" as well as prescription medication.*

Prescription medication must be in an original pharmacy-labeled container with prescription label containing student's name, name of health care provider, name of medication, dosage, route, time, and frequency. **Over-the-counter medication must be in the original manufacturer-labeled container** with student's name on the container. When the school supply of medication is depleted or expired, additional medication must be provided. Please provide the requested information below:

Student's Name_____ Birthdate_____ Grade_____

Parent_____ Phone_____ Teacher/Rm_____

I hereby request that the school assist with the administration of medication to my student during school. I give my consent for the school nurse or other designated school personnel to contact the healthcare provider to exchange information regarding the orders below. The medication(s) will be kept on site unless a physician gives authorization below for the student to carry medication(s) on his/her person. Designated school staff will assist the student unless a physician gives authorization below for the student to self-administer. I understand that health information may be shared with Miller Creek School District staff as needed.

I understand I am responsible to provide and maintain current medication in the original container(s).

***Signature of Parent/Guardian*_____ *Date*_____**

This section to be completed by the student's healthcare provider:

Medication: _____ Dose: _____ Route: _____ Frequency: _____

When to Administer: _____ Possible Side Effects: _____

Authorized to carry? Yes_____ No_____ Trained & Authorized to self-administer? Yes_____ No_____

Physician Signature: _____

Reviewed by District Nurse: _____

Date: _____

DOCTORS STAMP HERE: