13306 4th Street Hickman, CA 95323
Phone (209) 874-1816 Fax (209) 874-3721

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

In accordance with California Education Code section 49423, this form must be completed by an authorized California healthcare provider (MD, DO, PA, NP) and be on file for any student who requires medication(s) during the regular school day.

Student: (Last, First) _____ **DOB:** _____

Hickman: ☐ Elementary ☐ Middle ☐ Charter **Grade/Teacher:** _____

TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTHCARE PROVIDER

Medication 1:

Medication: _____ Reason for med: _____
Dosage: _____ Frequency: _____
Method of administration: _____
Time to be given: _____
Start: ☐ Now ☐ Other _____ Stop: ☐ End of school year ☐ Other _____
Restrictions and/or important side effects:
☐ None ☐ Yes, please describe _____
Special storage: ☐ No ☐ Yes _____

Medication 2:

Medication: _____ Reason for med: _____
Dosage: _____ Frequency: _____
Method of administration: _____
Time to be given: _____
Start: ☐ Now ☐ Other _____ Stop: ☐ End of school year ☐ Other _____
Restrictions and/or important side effects:
☐ None ☐ Yes, please describe _____
Special storage: ☐ No ☐ Yes _____

Healthcare provider name (Please print): _____ **License #:** _____

Office contact person: _____ **Phone:** _____

Provider signature: _____ **Date:** _____

TO BE COMPLETED BY PARENT OR GUARDIAN

I, the parent of _____, authorize the school nurse or other designated school personnel to administer the medication as directed by the authorized healthcare provider. I understand that the school nurse has my permission to communicate with the prescribing healthcare provider on matters related to this medication. I will notify the school if the medication has changed or is no longer needed. Medication will be furnished in its pharmacy-labeled container or original, unopened packaging. I understand that any medication not picked up within one week of the last day of school will be properly disposed of.

Parent/Guardian Name (Print)	**Signature**	**Daytime phone**	**Date**

Reviewed by Nurse (Print)	**Signature**	**Date**