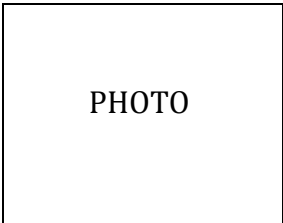


**MEDICATION FORM**  
**Santa Cruz County Schools**



**Student Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Parent/Guardian Name & phone #'s** \_\_\_\_\_

California Education Codes 49423 and 49480 permit administration of medication(s) by designated school personnel. Medication must be provided in original container labeled with the student's name, medication name, dose/strength, expiration date, & specific administration directions.

\*\*\*\*\*

**Parent/Guardian Authorization**

As the parent/guardian of the above named student, I request that designated school personnel assist in the administration of medication prescribed by the physician. I understand it is my responsibility to bring all medication safely to the school and I agree to refill or replace medication as necessary. I will notify the school immediately if there are changes in name, dose, route or time of medication administration. I understand that medication will be stored in a secure area unless the physician indicates below that my child is capable of carrying and self-administering it. I give consent for the physician and designated school personnel to communicate directly regarding the administration of medication.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Student Statement (only if authorized to self-carry medication):**

I understand that I am allowed to carry and self-administer only the medication(s) listed. I agree to use the medication as instructed by my physician and not to share with other people. I understand that if I share the medication with others, I will be held accountable for my actions and that I will face disciplinary action.

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*\*\*\*

**Physician/Prescriber Authorization**

**Diagnosis/ Reason for Medication** \_\_\_\_\_

**Adverse Reactions:** \_\_\_\_\_

<b>Name of Medication</b>	<b>Form: pill, cream, inhaler etc.</b>	<b>Dose/ Number to be taken</b>	<b>Time given Or PRN</b>	<b>PRN Reason</b>	<b>Initial if okay for student to carry and self administer</b>

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Discontinuation Date (one year unless specified)** \_\_\_\_\_

Clinic Stamp:

