DELTA ELEMENTARY CHARTER
36230 North School Street, Clarksburg, CA 95612
Phone: (916) 744-1200 | Fax: (916) 744-1246

Medication Required During School Hours Authorization Form

Note: This form must be completed with both Doctor and Parent/Guardian signatures **before** any medication can be administered at school.

California Education Code 49423 allows school nurses or other designated school personnel to assist students who are required to take medication during the school day. This service helps ensure that students can remain in school and supports their ability to learn and succeed.

All medication must be provided in the original container as dispensed by the pharmacy or manufacturer, with the label attached. It must be prescribed specifically for the student who will be receiving it. **No medications, including over-the-counter medications, will be administered at school without a current prescription from a physician or dentist.**

Student Information

Student Name: _____ **Birthdate:** _____

Teacher: _____ **Grade:** _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Examination: _____ **Diagnoses:** _____

Medication Prescribed: _____

Dosage: _____ **Times:** _____ **Route:** _____

Side Effects: _____

Signs & Symptoms for PRN (as needed) medication use:

Minimum Interval Between PRN Doses: _____

Potential Emergency Situations:

Note: If it is necessary for this medication to be taken during the school day at the time(s) indicated above, it may be administered by medically non-licensed personnel.

Physician's Signature: _____ **License #:** _____

Print Physician's Name: _____ **Date:** _____

Address: _____ **Phone #:** _____ **Fax #:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

By signing below, I verify that:

1. I am the parent or legal guardian of the student named above.
2. I authorize school personnel to administer the above medication to my child as directed by the health care provider.
3. I understand that the school is not legally obligated to administer medication to any pupil; therefore, I agree to hold Delta Elementary Charter School (DECS) harmless from any and all liability resulting from the administration of the medication as directed.
4. I give my permission for the exchange of confidential information regarding this medication and my child between DECS, and the physician named above.

Physician's Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Address: _____

Home Phone: _____ **Alternate Phone:** _____

This form must be renewed whenever the prescription changes and at the beginning of each school year.