Medication Authorization Form

This form is for any prescription or over-the-counter medications taken during school hours and in effect for only one school year. If medication is for asthma, seizures or severe allergies you must use the correct emergency care plan form.

Student's Legal Name: ____
(As it appears on birth certificate) *Last,* *First,* *Middle Initial*

Date of Birth: ____________ Grade Level: _______ School: ______________ School Year: ___________

Important Information

Your student or a Cambrian staff member cannot administer any medication without this signed form *(CA Education Code Section 49423).*

- All prescription and over-the counter medications are kept locked in the health center in the school office.
- Prescription medication must be in the **original container** labeled by a California pharmacy with the student's name, medication name, dose/strength and specific administration directions.
- Non-prescription (Over-the-counter) medications must be in the **original container** labeled by the manufacturer's label with the medication name, dosage, and instruction.
  - Over-the-counter medication includes and not limited to: Cough Drops, Pain Reliving Medications, Antacids, or Allergy Reliving Medications.

Medication Information and Authorization (*To be Completed by a Recognized Medical Authority**)

Name of Medication	Dosage Prescribed	Administration Time/frequency

Adverse effects: ____

Other comments/directions: ______________________________________

I certify that the above named child is under my care:

Office Stamp

Dr. ________________________________
Print Name (Last, First)

Physician's Signature: ______________________________________ **Date**: ____________

** Physician, Physician Assistant, or Nurse Practitioner licensed to practice in the State of California*

Parent/Guardian Authorization

I hereby authorize the school to administer the above listed medication(s). I give consent for the physician and school district to communicate directly, regarding the administration of the medication. I understand it is my responsibility to bring all medication safely to the school office and agree to refill or replace mediation as necessary.

Parent's Signature: ______________________________________ **Date:** ___________

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