CASTRO VALLEY UNIFIED SCHOOL DISTRICT

4400 Alma Avenue, Castro Valley, CA 94546 (510) 537-3000

AUTHORIZATION TO ADMINISTER PRESCRIBED and OVER-THE-COUNTER MEDICINE FORM

STUDENT INFORMATION

Student's Legal Last Name	First Name	MI	Grade	Date of Birth

Address	Phone	School

In accordance with California Education Code 49423, students in need of assistance with **prescribed and Over-the-Counter** medication during the regular school day must have on file: (1) a written statement from the physician and (2) a written statement form the parent or guardian. The forms below must be completed and on file in the school before a child can be given the prescribed medication. This request must be renewed yearly or when there is a change of medication or dosage.

Sandee Velasquez, R.N.,FNP, Credentialed School Nurse ph: 510-537-5910 ext. 3813 fax number: 510-582-7728
Elizabeth Erickson, R.N., M.S., District School Nurse ph: 510-537-3000 ext. 6137 fax number: 510-886-6005

For the Physician: please list the name of the medication, dose, time it is given, and possible side effects. Medication can not be dispensed at school without a formal request signed by a doctor and parent.

Name of Medication:	Dosage (how much):	Times Given:	Possible side effects:

PHYSICIAN'S AUTHORIZATION TO TAKE PRESCRIBED MEDICATION

Physician's Stamp Required:

Physician's Name: _____

Physician's address: _____

Physician's Telephone Number: _____

Begin Date: _____ **End Date:** _____ **Physician's Signature:** _____

PARENT/GUARDIAN'S AUTHORIZATION FOR SCHOOL PERSONNEL TO ADMINISTER PRESCRIBED MEDICATION

I relieve school personnel from responsibility for any untoward reactions resulting from administering this medication.

Supply of medication must be delivered to the school by a parent or parent designee in a container labeled by the pharmacist. The label is to include the students name, doctor's name, name and dosage of medication. Changes in dosage or time of administration must be verified, in writing, by the physician. Permission is granted to the school nurse to communicate with the physician as needed.

I understand that, whenever possible, the medication should be scheduled for a time when the child is not in class. There are no health professionals available to give medications.

Date	Parent/Guardian Signature	Parent/Guardian Printed Name

Date received: **Name of school personnel:**