ORDER FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

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

Student Last Name	First Name	Middle Initial	DOB: month/day/year	Grade/School Year

School Name	School Phone Number	School FAX number	Credentialed School Nurse (if applicable)

TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER: (California licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants – California Code of Regulations, Title 5, section 601[a])

A. **Nature of condition requiring medication during the school day**: _____

B. **Name of medication** _____

Method of Administration _____ **Dosage**_____

Amount time to be given _____**Frequency** _____

C. **Side Effects/Adverse reaction to report:**_____

D. **Discontinue medication on (date)** _____

E. **Medication may be administered by unlicensed volunteer school employee trained by a credentialed school nurse. (Authorized licensed health care provider initials :_____)**

F. Student is authorized to carry and is able to self-administer prescription for asthma or diabetes (Authorized licensed health care provider initials: _____)

G. Student is authorized to carry and is able to self-administer auto-injectable epinephrine independently (Authorized licensed health care provider initials: _____)

Authorized health care provider name (print)	Signature	Date

License Number	Phone Number	FAX number

PARENTAL AUTHORIZATION

I authorize the credentialed school nurse, licensed health care provider (RN, LVN), or trained unlicensed volunteer school employee designated by the site administrator, to administer the medication as directed by the authorized health care provider. I understand that the school nurse has my permission to communicate with the prescribing licensed health care provider on matters related to this medication.

Parent/Guardian name (print)	Signature	Daytime Phone Number	Date

Reviewed by credentialed school nurse name (print)	Signature	Date