

# PERMISSION TO GIVE MEDICATION AT SCHOOL

Oakdale Joint Unified School District  
California Education Code Section 49423 and 49423.5

STUDENT LAST NAME                      FIRST                      MIDDLE                      AGE                      DATE OF BIRTH

## \*\*TO BE COMPLETED BY THE PHYSICIAN

Name of Medication	Dosage	Method	Approximate Time of Day	Reason

Side Effects: \_\_\_\_\_

Precautions / Special Directions: \_\_\_\_\_

If PRN medication, list symptoms: \_\_\_\_\_

Does the above medication(s) need to be evacuated with the child in the event of an emergency?     Yes     No

Signature of MD or NP/PA & Supr. MD                      Lic.#/Furnishing #                      Address                      Phone

## \*\*TO BE COMPLETED BY THE PARENT/GUARDIAN

My child is under the care of Dr. \_\_\_\_\_. I understand it is my responsibility as the parent/guardian to keep the school supplied with a nd informed of any changes in my child's medication(s). I, or a designated adult, will bring the medication to the school in its original container or prescription bottle. I also understand it is my responsibility to monitor expiration dates of all prescription or over-the-counter medications I bring to school. I authorize the school nurse to communicate with the health care provider when necessary.

I give permission to \_\_\_\_\_ School to administer medication  
(Name of school)  
to my child, \_\_\_\_\_  
(Name of child)

Parent/Guardian (Print): \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date: \_\_\_\_\_

*A new form is required every school year and if there are changes in the medication(s) or dosage(s).*

*\* Please pick up all medications from school site at the end of each school year. Medications not picked up will be discarded.*