AUTHORIZATION FOR MEDICATION TO BE TAKEN AT SCHOOL

The top section is to be completed by the PARENT/GUARDIAN:
School:_________________________________Grade:________
Student's Name:______________________________________
Birth Date:____________________
Gender: M F
Health Care Provider's Name:____________________________
Address:____
Phone & Fax:____
Please check only one box:
___I request that authorized persons at school assist my child in taking the medicine(s) described below. I also give my permission for exchange of information between school staff and the health care provider.
___I request that my child be allowed to self-administer medication. I also give my permission for exchange of information between school staff and the health care provider. I shall hold harmless and indemnify California Virtual Academies and its officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by my child.
Parent/Guardian Signature:________________________________
Date:____
Home Phone:____
Cell Phone:____

The bottom section is to be completed by the HEALTH CARE PROVIDER:
I have determined that the medication named below is advisable during the school day.
Diagnosis for which medication is given:_______________________
Name of medicine:________________Dose:_________________
___Tablet/Capsule___Liquid___Inhaler___Injection___Nebulizer_______
Other:____
If medicine is to be taken DAILY, at what time?___________________
If medicine is to be given WHEN NEEDED, describe indications:_______
____
How soon can it be repeated?_______________________________
Is child authorized to medicate himself/herself?___yes___no
If “yes”, student has been trained by health care provider and is safe to self-administer?
___Yes___No
Length of time this treatment is recommended:____________________
Possible side effects:_____________________________________
Emergency procedure in case of serious side effects:_______________
____
Health Care Provider's Signature:____________________________
Date:____
(Adapted from the American Academy of Pediatrics, HEO150)

Please note the following:
ALL MEDICATIONS TO BE ADMINISTRATED AT SCHOOL
REQUIRE A REQUEST FROM A LICENSED HEALTH PROFESSIONAL.
Medication must be in a properly labeled container from the dispensing pharmacy, including:
-Student’s Name

-Name of Medication
-Strength of Medication
-Time and Method of Administration
  -Length of Time/Days to be given