



GRIDLEY UNIFIED SCHOOL DISTRICT
429 Magnolia St., Gridley, CA 95948
AUTHORIZATION FOR MEDICATION TO BE GIVEN AT SCHOOL

Student's Name: _____ Birthdate: _____ School Year: _____

Teacher: _____ School Site: _____

Dear Parent/Guardian/Healthcare Provider:

California Educational Code, Section 49423 provides that any pupil required to take medication during regular school days, may be assisted by the school nurse or designated school personnel. **ALL MEDICATIONS WHETHER PRESCRIPTION OR NON-PRESCRIPTION REQUIRE DOCTOR AND PARENT AUTHORIZATION, AND MUST BE IN THEIR ORIGINAL CONTAINERS AND CURRENT PRESCRIPTION BOTTLES.**

(1) Medication to be administered: _____
Dosage: _____ How Often: _____ Time of Day: _____ Duration: _____
Anticipated reactions to medication: _____

(2) Medication to be administered: _____
Dosage: _____ How Often: _____ Time of Day: _____ Duration: _____
Anticipated reactions to medication: _____

The proper use and risk of carrying an **INHALER** or **EPIPEN** on the school premises will be the responsibility and liability of the student and parent.

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Medical Provider: **Write your initials** in the box if you feel it is medically necessary for this student to carry the above prescribed **INHALER** or **EPIPEN** with him/her during school hours, and you observed and approved student's technique of self-administration.

X

Physician's Signature

Date

Physician's Printed Name

Telephone

I approve of this authorization for medication to be given to my child by school personnel.

X

Parent/Guardian Signature

Date

Phone (H/C) _____ (W) _____

1. All medications must be in a container labeled by a pharmacist. If OTC medication, must be in original container.
2. An adult must bring the medication to the school and pick up any outdated, unused or for home use medication.
3. All medications not picked up by an adult on the last school day will be discarded, unless otherwise arranged.
4. Parents/Guardians must provide all material or necessary equipment for medication administration.

AUTHORIZATION FOR EXCHANGE OF INFORMATION

I hereby give my permission for the exchange of information regarding my child's medication:

Student's Name

between: _____ and _____
(Name of Physician) (Name of School)

X

Parent/Guardian Signature

Date