



Orange County Department of Education  
Instructional Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
School/District: \_\_\_\_\_ Teachers Name: \_\_\_\_\_ Grade/Track: \_\_\_\_\_

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION  
PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: (Work) \_\_\_\_\_ (Home) \_\_\_\_\_

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

If PRN: Amount of time between doses \_\_\_\_\_ Maximum number of doses \_\_\_\_\_ per day.

Possible medication reactions: \_\_\_\_\_

Instructions for emergency care \_\_\_\_\_

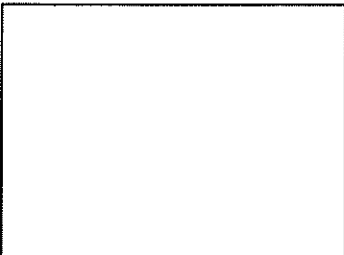
Authorized Health Care Provider Signature: \_\_\_\_\_

Authorized Health Care Provider Name (print clearly): \_\_\_\_\_

Telephone \_\_\_\_\_

Date of Request: \_\_\_\_\_

Date to Discontinue Medication: \_\_\_\_\_



Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials \_\_\_\_\_

SCHOOL USE:

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

This request is valid for a maximum of one year.