

Calaveras Unified School District  
P.O. Box 788  
San Andreas, CA 95249

**MEDICATION REQUIRED DURING SCHOOL HOURS**

THIS FORM MUST BE COMPLETED WITH M.D./DENTIST AND PARENT/GUARDIAN SIGNATURES BEFORE ANY MEDICATION CAN BE ADMINISTERED AT SCHOOL.

California Education Code 49423 allows the school nurse or other designated 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 to maintain or improve the potential for education and learning.

Medication must be in the container in which it was purchased with the pharmacy label attached, and must be prescribed to the student to whom it will be administered. No medications (including over-the-counter medications) will be given at school without current M.D. / Nurse Practitioner / Dentist / Podiatrist prescription.

Student name: \_\_\_\_\_ Date: \_\_\_\_\_

School of Attendance: \_\_\_\_\_

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**TO BE COMPLETED BY HEALTH CARE PROVIDER**

Date student was examined: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medication Prescribed: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time: \_\_\_\_\_ Route: \_\_\_\_\_

Medication to be administered until: \_\_\_\_\_ (date)

It is necessary for this medication to be taken during the school day at the time(s) indicated above, and the medication may be administered by medically untrained personnel.

Physician's signature: \_\_\_\_\_ License #: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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**TO BE COMPLETED BY PARENT/GUARDIAN:**

I authorize school personnel to administer the above medication to my child as ordered by the Health Care Provider.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

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

This form must be renewed whenever the prescription changes and at the beginning of each school year.