Grossmont Union High School District
AUTHORIZATION FOR MEDICATION ADMINISTRATION
Education Code 49423

I, _____ the undersigned, as legal parent/guardian of _____
Student's Name / Birthdate

attending _____ *I* requests that the following medicine(s): _____
School

_____

be made available to my child at the times prescribed: _____

I understand that only personnel authorized by the school principal will assist my child in taking the medicine(s) as directed by my physician.

I will provide the medicine(s) *in the prescription container(s),* which is labeled with the name of my child, the prescribing physician's name, and amount of medication prescribed.

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Prescription and nonprescription medications are not permitted to be taken at school without a written statement from the physician and a written statement from the parent indicating desire that the district assist the student as set forth in the physician's statement below.

I recognize that this is a service or accommodation that the school is not legally required to perform. I agree to save and hold the district, its officers, employees, or agents harmless from liability, suits or claims of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

_____
Signature ***Date***

_____
Home Address

_____
Home/Mobile/Work Phone Number

This form valid for school year 2023-24.

THIS PORTION TO BE COMPLETED BY A PHYSICIAN LICENSED IN THE STATE OF CALIFORNIA

1. ****Name of Medication, Method of Administration, Dosage Appx., Time of Day**

A. _____

B. _____

2. Discontinue "Medication A" on _____ and "Medication B" on _____.
Date ***Date***

3. Type of assistance for administering medication (observe, measure, etc.):

_____

4. Precautions for administration or storage of medication:

_____

5. Do you wish to have school personnel contact you at intervals to discuss this medication?

☐ Yes ☐ No

Please indicate: Person(s) _____ Intervals _____
Teacher, Nurse ***Weekly, Quarterly, etc.***

****If medication is an inhaler, epi-pen, or insulin, and may be carried on person, check here ☐.**

****If glucose testing equipment will be carried on person, check here ☐.**

_____, M.D. _____
Printed Name of Physician Medical License Number

_____ _____ _____
Signature of Physician Phone Number Date