Berkeley PUBLIC SCHOOLS
Berkeley Unified School District

# MEDICATION AUTHORIZATION

*RETURN COMPLETED FORM TO SCHOOL*
*WITH GUARDIAN AND HEALTH CARE PROVIDER SIGNATURES*

**Student's Name:** _____ **Date of Birth:** _____

**School:** _____ **Grade:** _____ **Room/Teacher:** _____

## PARENT/GUARDIAN AUTHORIZATION:

When the district has received written orders from the student's physician and written permission from the parent/guardian, designated personnel shall assist students who are required to take medication during the school day. All medication must be delivered to the school by the parent/guardian in an **original container and appropriately labeled** by the pharmacy. Parents/guardians can request that the pharmacist dispense two bottles of medication, one for home and one for school. Written permission must also be provided for students to carry and self-administer prescribed medication such as asthma inhalers and EpiPens. (CA Education Code 49423; BUSD Board Policy 5141.21).

I request and authorize designated school personnel to assist my child with medication administration in accordance with our health care provider's written instructions below. I will notify the school immediately and submit a new form if there are changes in any of the information provided. I authorize school personnel to consult with our Health Care Provider about my child's medical needs as necessary. I understand that I can terminate this consent at any time.

**Parent/Guardian signature**: _____ Date: _____

Telephone: (home) _____ (work) _____ (cell) _____

## HEALTH CARE PROVIDER AUTHORIZATION:

| Name of Medication or Treatment | Reason | Dosage | Route | Time | Refrigerate? (Y/N) | Self-Administer? | Self-Carry? (Y/N) |
|---|---|---|---|---|---|---|---|
| | | | | | ❑ No<br>❑ Yes | ❑ No<br>❑ Yes, supervised<br>❑ Yes, unsupervised | ❑ No<br>❑ Yes |
| | | | | | ❑ No<br>❑ Yes | ❑ No<br>❑ Yes, supervised<br>❑ Yes, unsupervised | ❑ No<br>❑ Yes |
| | | | | | ❑ No<br>❑ Yes | ❑ No<br>❑ Yes, supervised<br>❑ Yes, unsupervised | ❑ No<br>❑ Yes |
| | | | | | ❑ No<br>❑ Yes | ❑ No<br>❑ Yes, supervised<br>❑ Yes, unsupervised | ❑ No<br>❑ Yes |

Diagnosis/Significant Findings: _____

Allergies (Medication and other substances): _____

**Health Care Provider signature**: _____ Date: _____

Address: _____ Telephone: _____

***This request is valid for a maximum of <u>one</u> year.***