JURUPA UNIFIED SCHOOL DISTRICT
Education Support Services
4850 Pedley Road
Jurupa Valley, California 92509

MEDICATION ADMINISTRATION FORM

NOTE: THIS AUTHORIZATION FOR ADMINISTRATION OF MEDICATION HAS BEEN APPROVED BY ALL SCHOOLS IN RIVERSIDE COUNTY.

		Date:	School:
Student Name:	DOB:	Student ID #:	Grade:

EDUCATION CODE AUTHORIZATION
EDUCATION CODE 49423

Any pupil who is required to take, during the regular school day, medication prescribed for him/ her by a physician, may be assisted by the school nurse or other designated personnel if the school district receives (1) a written statement from such physician detailing the method, amount and time schedules by which such medication is to be taken and (2) a written statement from the parent/ guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement. **Any medication, including over the counter, shall be in a prescription labeled pharmacy bottle.**

I request that the school nurse or designated staff assist my child with medication as authorized by the physician. I agree to hold Jurupa Unified School District, its officers or employees harmless from all liability or claims that might arise out of arrangements as specified by the physician. I understand that the physician will be contacted as needed for clarification with my permission.

_____ _____ _____ _____
Parent/ Guardian Signature Home Phone Work Phone Date

PHYSICIAN AUTHORIZATION

Name of Medication(s):	Health condition for which medication prescribed:
Time(s) to be taken:	Dosage:
Method of administration:	Precaution – possible untoward reactions:
Date to be discontinued:	Physician's telephone number:
Name of Physician (please print)	Physician's Signature/ Date

Please return this form to your child's school Health Office signed by the physician and the parent or guardian. NO MEDICATION WILL BE ADMINISTERED WITHOUT THESE REQUIRED SIGNATURES. All medications shall be brought to the school office by an adult and be kept in the Health Office.

-THIS FORM IS TO BE RENEWED ANNUALLY-

Distribution Copies: Health Office/Student's Doctor/Parent