DIOCESE OF ORANGE

OFFICE OF FAITH FORMATION
CATHOLIC SCHOOLS

Fax (714) 840-0498

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICINE

Name of Student: _____   Birth Date _____

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 healthcare provider written instructions. I understand that designated non-medical school personnel will administer medication under supervision of the school administration. 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.

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

Telephone _____

Date of Request: _____

Date to Discontinue Medication: _____

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency EpiPen/Inhaler. 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.