NEWHALL SCHOOL DISTRICT
Authorization to Administer Physician-Prescribed Medications

Dear Parent or Guardian:

The Newhall School District wants to assist you, your physician, and your child with authorized physician prescribed medicines. This form requires **your signature** and the **signature of your physician** in order for your child to be administered medication in the school setting. Please sign and then **take this form to your physician for his/her signature.*** **Medication cannot be administered at school unless this form is completed and returned to the school. This includes over the counter medications.**

I authorize personnel of the Newhall School District to administer physician prescribed medicines to my child, in conformity with California Education Code Section 49423. If this authorization is for a continuing medication given on a daily basis at school, this authorization is effective only through the last day of the current school year and will need to be renewed thereafter.

_____ _____ _____
Name of Child M/F Date of Birth

_____ _____
Parent Signature Date

The completion of this form will authorize Newhall School District to contact your child's physician with questions pertaining to the administration of the medications listed below.

Attention Physician:
The medication listed below is prescribed for _____and needs to be
(condition)
taken during school hours. This medication is prescribed from _____to_____(dates) and is effective only through the last day of the current school year and will need to be renewed thereafter.

Name of Medication	**Dose**	**Route**	**Time(s)**

Possible side effects: _____Sleepiness _____Dizziness _____Stumbling _____ Other
_____Irritability _____Headache _____Stomach ache
_____Nausea/vomiting _____ Photosensitivity _____Diarrhea

Note: Medication given at home may also modify learning behavior. Therefore, we request information regarding any physician-prescribed medication given at home.

The medication listed below is prescribed for this child to be taken only before 8:00 a.m. or after 3:00 p.m.

Medication: _____ Purpose: _____

***Physician's Signature**:_____ Physician's Phone No. _____

Physician's Name (printed):_____

Physician's Address: _____

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