



# KAVOD ELEMENTARY CHARTER SCHOOL

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## Authorization for Medication To Be Given At School

California Education Code 49423 allows the school nurse or other designated 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 the potential for education and learning.

1. Medicine must be brought to school by the parent/guardian. Bring the medication to school in a container labeled by the pharmacy with the child's full name, medication name, dosage schedule, name of prescribing doctor and expiration date.
2. A note from home is not enough. Parent/guardian and physician must complete and sign this form.
3. Authorization form with physician's signature is also required for non-prescription (over-the-counter medications) such as cough syrup, tylenol, cortizone creams, etc. These medications must be brought in the container in which they were purchased. Whenever possible we encourage medication to be given at home: Short-term medications (antibiotics, etc.) can usually be spaced to be taken when the student is at home. Example: Four times a day - one before school, one right after school, one at dinner and one at bedtime.
4. If any of the conditions in the Physician's Statement change, and at the beginning of each school year, a new form must be signed by the parent/guardian and the physician. A separate form is required per each medication.

By law, no exceptions can be made to these rules. If they are not followed, we cannot give your child medication at school. It will then be necessary for you to come to the school and give the medication.

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### TO BE COMPLETED BY HEALTHCARE PROVIDER:

Name of Student: \_\_\_\_\_ Date of examination: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medication Prescribed: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency/Times: \_\_\_\_\_

Signs & symptoms for which medication is to be taken: \_\_\_\_\_

Treatment of emergency situations: \_\_\_\_\_

Date medication will end (one year maximum): \_\_\_\_\_

Healthcare Provider's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Healthcare Provider's Name (print): \_\_\_\_\_

CA Medical License #: \_\_\_\_\_ Phone: \_\_\_\_\_

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### TO BE COMPLETED BY PARENT/GUARDIAN:

My signature below verifies that:

1. I authorize my child to receive the medication as ordered above, and I authorize the school's health services to communicate with appropriate school staff regarding this medication order.
2. I give my permission for the exchange of confidential information regarding my child named above between the school and the above named healthcare provider as it relates to the above medication.
3. I release the school and school personnel from civil liability resulting from the student taking medication in the manner directed.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name (Print): \_\_\_\_\_