**MERIDIAN ELEMENTARY SCHOOL DISTRICT**
**MERIDIAN ELEMENTARY SCHOOL**
15898 Central Street, Meridian, CA. 95957
Phone: 530-696-2604 / Fax: 530-696-0406

## AUTHORIZATION FOR MEDICATION TO BE GIVEN AT SCHOOL

Pupil Name ______________________________ Birthdate ____________________
School Year __________ Teacher ______________________________________

Dear Parent/Care Provider:

California Education Code, Section 49423 provides that any pupil required to take, during regular school days, medications prescribed by a physician may be assisted by the school nurse or other designated personnel if the school district receives specified written statements from such physician and the parent/guardian of the pupil.

1) Medication to be administered ______________________________________
Dosage: ___________________________ How Often: ________________
Time of Day: ________________________ Duration: __________________
Anticipated reactions to medication: _____________________________________
______________________________________________________________

2) Medication to be administered ______________________________________
Dosage: ___________________________ How Often: ________________
Time of Day: ________________________ Duration: __________________
Anticipated reactions to medication: _____________________________________
______________________________________________________________

Educational observations of children on mediation will be made when necessary. If you desire to receive these reports, please contact the school.

| ______________________ | __________ | ______________________ | __________ |
|---|---|---|---|
| Physician's Signature | Date | Physician's Printed Name | Telephone |

I approve of this authorization for medication to be given to my child by school personnel.

______________________ __________ Phone (H) ___________ (W)________
Parent/Care Provider Signature Date

### PARENT'S AUTHORIZATION OR EXCHANGE OF INFORMATION

I hereby give my permission for the exchange of information regarding my child's medication:

______________________________________ ____________________
(Student name) (Birthdate)

between ______________________________ and Meridian Elementary School
(Name of Physician)

______________________________ ____________________
Signature of Parent/Guardian Date