Medication Confirmation Form

School Name: _____

Student Name:_____ **Date of Birth:** _____ **Sex:** _____

All prescription and over-the counter medications are kept locked in the health center and will be administered only as authorized by the parent and/or child's physician. Important: We cannot administer any medication sent with your child without this signed form.

Steps to complete the Medication Authorization Form:

1. Medication must be prescribed by a California licensed physician and provided by a California licensed pharmacist. Medications from Mexico or authorizations from Mexican physicians are not authorized by law.
2. All medication, both prescription and non-prescription, require a physician's signature, medical license number, and complete (legible) instructions from the physician.
3. Verify that:
    a. All prescription and non-prescription medications are in their original containers.
    b. Prescription medications are properly labeled by the California pharmacy, including:
        1. Student's name (prescription must be for the student only, no other name)
        2. Medication name
        3. Precise dosage instructions, quantity and frequency
        4. Physician's name
        5. School's name
    c. Non prescription medications are properly labeled, including: 1) Manufacturer's label with the medication name, dosage, and instructions. 2) Add your child's name (last name first). 3) The school's initials.
    d. Spanish labels must be translated to English on the Authorization Form.
    e. Medications must not be expired.
4. Fold this form and place it in a zip lock bag with all the medications (both prescription and non-prescription in their original containers) and turn the bag in to your child's school administrators as directed.
    a. Label the zip lock bag with your child's full name and school name.
    b. DO NOT send any medication to the site in your child's luggage.
    c. Homeopathic, herbs, and vitamins require a medical form completed by your physician.

Medication Name: _____ Strength: _____

Dose Quantity: _____ Form (pill, spray, etc.) _____

Frequency (check one): Scheduled ☐ As Needed ☐

Times Given (if scheduled): _____

Reason for Medication: _____

Additional Instructions (if any): _____

HEALTHCARE PROVIDER AUTHORIZATION

Healthcare Provider: _____ **CA License #:** _____

Address: _____ **Phone #:** _____

Signature: _____ **Date:** _____