Valid for School Year
________ to ________

BONSALL UNIFIED SCHOOL DISTRICT
31505 Old River Road, Bonsall, CA 92003
(760)631-5200

PARENT/GUARDIAN AND PHYSICIAN MEDICATION AUTHORIZATION
(Education Code Section 49423)

PARENT AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

I request that medication be administered to my child:

________________ ________________ ________________
(Name) (Birthdate) (School)

in accordance with our physician's written instructions. I understand that designated school personnel will administer medication under supervision of a qualified School Nurse. ***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 physician and give permission to contact the physician when necessary.***

Parent/Guardian Signature: ____________________ **Date:** ____________________

MEDICATION MUST BE IN THE ORIGINAL LABELED CONTAINER FROM PHARMACY.

PHYSICIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
(To be completed by a physician licensed in the state of California)

	Medication	Method of Administration	Dosage	Time(s)	Discontinue Date
#1					
#2					
#3					
#4					

List any precautions for administration or storage of medication:

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Printed Name of Physician **Medical License Number** **Date**

Signature of Physician **Telephone Number** **Fax Number**