# DIXON MONTESSORI CHARTER SCHOOL

355 No. Almond St. • Dixon, CA 95620
Phone: (707) 678-8953 ~ Fax: (707) 676-5215

## Medication Required During School Hours Authorization

This form to be completed with MD/Dentist and Parent/Guardian signatures before any medication can be administered at school.

California Ed. 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.

**Medication must be in the container in which it was purchased with the pharmacy or manufacturer's label attached and must be prescribed to the student to whom it will be administered. No medications (including over-the-counter medications) will be given at school without a current physician/dentist prescription.**

**Student Name:** _____ **Birthdate:** _____

**Teacher:** _____ **Grade:** _____

**TO BE COMPLETED BY HEALTH CARE PROVIDER:**

Date of Examination: _____ Diagnoses: _____

Medication Prescribed: _____

Dosage: Times: Route:

Side effects: _____

Signs & Symptoms for which a PRN (as needed) medication is to be administered:

_____

Minimal interval for PRN medication: _____

Potential emergency situations: _____

**If it is necessary for this medication to be taken during the school day at the time(s) indicated above, the medication may be administered by medically non-licensed personnel.**

Physician's Signature: _____ License #: _____

Print Physician Name: _____ Date: _____

Address: _____ Phone #: _____ Fax #: _____

**TO BE COMPLETED BY PARENT/GUARDIAN:**

**My Signature below verifies that:**

1. I am the parent or legal guardian of the student named above.
2. I authorize School Personnel to administer the above medication to my child as ordered by the above Health Care Provider.
3. I understand that the school is not legally obligated to administer medication to any pupil; therefore I agree to hold DMCS harmless from any and all liability resulting from administration of the medication in the manner directed.
4. I give my permission for the exchange of confidential information of my child named above between DMCS and

_____ as it relates to the above medication.
(Physician's Name)

Parent or Guardian Signature: _____ Date: _____

Address: _____

Hm Phone: _____ Alt. Phone: _____

* This form must be renewed whenever the prescription changes and at the beginning of each school year. *