AUTHORIZATION TO ADMINISTER MEDICATION

If your child is required to take medication during the school day, please complete this form. This form requires your signature and the signature of your physician in order for us to administer medication at school. Please sign and then take this form to your physician for his/her signature. Medication cannot be administered at school unless this form is completed and returned to the school. This includes over the counter medications. If this authorization is for a continuing medication given on a daily basis at school, this authorization is effective only through the last day of the current school year and will need to be renewed thereafter.

I authorize personnel of **Willowcrest School** to administer physician prescribed medicines to my child, in compliance with California Education Code Section 49423.

______________________________ ______________________________
Student Name **Date of Birth**

______________________________ ______________________________
Parent/Guardian Signature **Date**

Physician Name ____

Telephone Number ____

The medication/s listed below is prescribed to ____________________**(student name)**

for___________________________________**(condition) and must be taken during school hours.**

This medication is prescribed from ___________________________________ **(dates)**

Name of Medication	Dosage	Method of administering	Time(s)

Possible side effects: (check all that apply):

__Sleepiness **__Dizziness** **__Stumbling**
__Irritability **__Headache** **__Stomach ache**
__Nausea/vomiting **__Photosensitivity** **__Diarrhea**
__Other

______________________________________ ______________________
Physician Signature **Date**

willowcrestschool.com