OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

Credentialed School Nurse Use Only

Orders expiration date ______________
Medication expiration date ______________

Authorization for Medication

Student's Name: ____________________________________ Date of Birth: ____________________

School: ____________________________ Grade: _____ Teacher: _______________ Room: _______

The California Education Code relating to the giving of medications at school states:

49423, Notwithstanding the provisions of Section 49422, any student who is required to take, during the regular school day, medication prescribed for him/her by a healthcare provider, may be **assisted** by the school nurse or other designated school personnel if the school district receives (1.) a written statement from such provider detailing the method, amount, and time schedules by which such medication is to be taken and (2.) a written statement from the parent or guardian of the student indicating the desire that the school district assist the student in the matter set forth in the provider's statement.

TO BE COMPLETED BY A LICENSED PROVIDER

Name of Medication (generic and brand)	Reason for Medication	Route	Dosage	Time	Self-Administer	Self-Carry
1.					□ No □ Yes, supervised □ Yes, unsupervised	☐ No ☐ Yes
2.					□ No □ Yes, supervised □ Yes, unsupervised	☐ No ☐ Yes
3.					□ No □ Yes, supervised □ Yes, unsupervised	☐ No ☐ Yes

Please Note:

- **All medication must be brought to school in an original container and appropriately labeled by the pharmacist.**
- **School Nurse and prescribing provider may communicate to clarify matters related to this medication.**
- **New orders are required annually and for any changes in medication regimen.**

Provider's Name (Please Print): ____________________________________ **Phone:** ____________________

License No.: _________________________________**NPI No.:** ______________________________________

Provider's Signature: ____ **Date:** ______________________

I request that the school nurse, or other person designated by the principal, administer the medication as directed by the physician:

Parent/Guardian Name (Please Print): ___________________________________ **Phone:** ____________________

Signature: ____ **Date:** _____________________

Reviewed by (Name of School Nurse): ___________________________________ **Phone:** _____________________

Signature of School Nurse: ____ **Date:** ______________________