MARCUM-ILLINOIS
Union Elementary School District

Authorization To Administer Medication

STUDENT MEDICATION – Legal Reference: Education Code Section 49423 "…any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated school person, if the school district received (1.) a written statement from such a physician detailing the name of the medication, 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 pupil indicating the desire that the school district assist the pupil in the matter set for in the physician's statement." No other medication is to be administered by school personnel. This includes all medication available without a prescription. **Medication is to be sent in the original container labeled with the name of the student, name of prescribing physician, name of medication and instructions. This form must be completed and included. It is the parent's responsibility to update this form as needed.**

07-08

Student: ______________________ **Date of Birth:** ____/____/____ **School Year:** 2026-2027

Teacher: ______________________ **School Site:** Marcum-Illinois Union ESD

Health Care Provider: ______________________

Phone: ______________________ **Fax:** ______________________

1.

Medication(s)	Dose	Frequency	Duration	Possible Side Effects

2. Additional Information and/or Precautions regarding medications or student's condition:

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3. I am the parent/guardian of the above student and I have lawful custody of said child. I hereby give consent to designated school personnel to administer or assist in administering medication(s) and/or treatment as specified by his/her health care provider. Furthermore, I hereby give consent to the School to receive from, or send to, the health care provider any information concerning my child's medical condition.

Parent/Guardian Signature ______________________ **Date** ____/____/____

4. HEALTH CARE PROVIDER: I am a physician actively licensed by the state of California. **Attached hereto is a prescription for the medication/treatment specified above.**

☐ **YES** ☐ **NO** **(FOR INHALER) Student may carry and self-administer his/her inhaler while on school property or at school-related events.**

PHYSCIAN SIGNATURE ______________________ **Date** ____/____/____