

**West Sonoma County Consortium  
School Nurse Services**

**Authorization for Assisting Self Administration of Medication**

The California Education Code provides for any pupil who is required to take medication prescribed by a physician during the regular school day if the following is received:

1. A written statement from the physician including name of student, the medication, dosage, and time to be given.
2. A signature from the parent or guardian indicating the desire that the school district assist the pupil with the medication, as outlined by the physician.
3. Medication must be in the original prescription or over the counter bottle.
4. This release is valid for one year from date of physician's signature.
5. Any medication remaining at the end of the school year must be picked up by the parent or it will be discarded.
6. This applies to over-the counter medication (such as Tylenol/Advil) as well.

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

The following medication has been prescribed for the student named above:

Medication: \_\_\_\_\_ Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time: \_\_\_\_\_ Time: \_\_\_\_\_

Side Effects: \_\_\_\_\_ Side Effects: \_\_\_\_\_

Student has permission to carry and self administer and has been trained in the use of :  
\_\_\_\_\_ Inhaler \_\_\_\_\_ Epi-Pen \_\_\_\_\_ Insulin syringe, pen or pump

Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

In signing below the parent or guardian gives permission for trained school personnel to assist the child in taking the medication as needed and gives permission for the physician to exchange relevant medical information with the School Nurse.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_