Acalanes Union High School District
Medication Form/Parent Permission

Please fill out and submit to the School Nurse upon student's initial enrollment with the AUHSD and annually thereafter, and/or whenever there are changes to medication-related information.

You can complete this form on your own computer. To move from field to field, use the Tab key. You may then print the completed document and if desired, save the document template to your own computer.

Date: _____ **Student's Name:** _____ _____ _____
(Last) (First) (Middle)

School: _____ **Grade:** _____
(Full Name of School)

Acalanes H.S.
1200 Pleasant Hill Rd.
Lafayette 94549
Fax 925-280-3971

Campolindo H.S
300 Moraga Rd.
Moraga 94556
Fax 925-280-3951

Ctr. for Ind. Study
1963 Tice Valley Blvd.
Walnut Creek 94595
Fax 925-280-3983

Las Lomas H.S.
1460 S. Main St.
Walnut Creek 94596
Fax 925-280-3921

Miramonte H.S.
750 Moraga Way
Orinda, CA 94563
Fax 925-280-3931

Medication to be given at school:

Medication	Dosage	Time/frequency	Administration Route	Reason for medicine

To be completed by the Authorized Health Care Provider:

Student has permission to carry certain designated emergency medication at school (includes inhalers, insulin, allergic reaction kits) and self-administer such medication under the supervision of school personnel.

Permission: **Y** or **N** _____

Physician office stamp

Signature of Physician: _____

Name of Physician: _____ **Date:** _____

To be completed by the Parent/Guardian:

California Education Code Section 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. The parent/guardian is responsible for providing the medication, which should be sent in the original bottle and labeled with the student's name.

I request that medication be administered to my child in accordance with our authorized health care provider written instruction. I understand that designated non-medical personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible side effects.

Signature of Parent or Guardian: _____ **Date:** _____

Name of Parent or Guardian: _____

Medications given at home:

Medication	Dosage	Time given