WILLOWS UNIFIED SCHOOL DISTRICT

Murdock Elementary School
655 French Street
Willows, CA 95988
Phone (530) 934-6640
Fax (530) 934-6557

Willows Intermediate School
1145 West Cedar Street
Willows, CA 95988
Phone (530) 934-6633
Fax (530) 934-6697

Willows High School
203 North Murdock St
Willows, CA 95988
Phone (530) 934-6611
Fax (630) 934-6619

AUTHORIZATION FOR ASSISTANCE WITH MEDICATION DURING SCHOOL HOURS

California Education Code 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain or improve the potential for education and learning.

Medication must be in the container in which it was purchased with the California pharmacy or manufacturer's label attached and must be prescribed to the student to whom it will be administered. No medications (including over-the-counter medications) will be given at school without a current California physician/dentist prescription.

Student name: _____ Birthdate: _____ School: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Date of examination: _____ Diagnosis: _____

Medication Prescribed: _____

Dosage: _____ Time/s: _____ Route: _____

Side effects: _____

Signs & Symptoms for which a PRN (as needed) medication is to be administered: _____

_____

Minimum interval for PRN medication: _____

Please encourage scheduling of medications during non-school hours:

_____

It is necessary for this medication to be taken during the school day at the time(s) indicated above. Unlicensed staff may assist the student with the medication.

Physician's signature: _____ License No.: _____

Physician's name: _____ Date: _____

Address: _____ Phone: _____

TO BE COMPLETED BY PARENT/GUARDIAN: My signature below verifies that:

1. I am the parent or legal guardian of the pupil named hereon.
2. I authorize school personnel to assist my child with the above medication as ordered by the above health provider.
3. I understand that the school nurse may communicate general medication information to school staff.
4. I give my permission for the exchange of confidential information of my child named above between Willows Unified School District and the above named physician as it relates to the above medication.
5. The school will be notified immediately if there is a change in physician, medication, or instructions.

Parent/Guardian Signature: _____ Date: _____

Address: _____ Home Phone: _____ Work Phone: _____

********** This form must be renewed whenever the prescription changes and at the beginning of each school year.********