

AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIBED MEDICATION ADMINISTRATION AT SCHOOLS WITHIN THE COUNTY OF RIVERSIDE

| | | | |
|-----------------|---------------|-------|--------|
| Name of Student | Date of Birth | Grade | School |
|-----------------|---------------|-------|--------|

Physician Authorization ONE MEDICATION PER FORM

| | |
|----------------------------------|---|
| Name of Medicine(s) | Health Condition for which medicine RX |
| Time(s) to be taken | Dosage |
| Method of administration | Precaution-Possible untoward reactions |
| Date to be discontinued | Physician's Telephone Number () |
| Name of Physician (Please Print) | Physician's Fax Number () |
| Physician's Signature | Date |

The above mentioned student must carry this medication on his/her person. **The student has demonstrated knowledge of the correct dosage and administration and is sufficiently responsible to administer it as ordered and needs no monitoring.**

The principal or designee reserves the right to revoke the privilege if the student demonstrates irresponsible behavior or incorrect administration.

I request that my student be allowed to carry their medication. I desire Murrieta Valley Unified School District, its officers and employees to comply with the orders of the above physician and will inform the school of any changes from the above. We further agree to hold the School District, its officers and employees harmless if any injury occurs to our child due to unsupervised use of prescribed medication at school per this request.

Parent/Guardian Signature

Home Phone

Work Phone

Date

Please return this form to your child's school health office signed by the physician and the parent or guardian.

**THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR
OR WHENEVER THERE IS A CHANGE IN MEDICATION OR INSTRUCTIONS.
PLEASE SEE RESPONSIBILITIES ON REVERSE SIDE.**