AUTHORIZATION FOR PRESCRIBED AND OVER THE COUNTER MEDICATION ADMINISTRATION AT SCHOOLS WITHIN THE COUNTY OF RIVERSIDE

Name of Student	Date of Birth	Grade	School

Education code 49423 authorizes that 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 personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.

I request medication prescribed be administered to my student and agree to hold Murrieta Valley Unified School District, it's officers or employees harmless from all liability or claims which might arise out of these arrangements. I give my permission to contact the physician for consultation as needed. I understand that all medication will be destroyed at the end of the school year unless other arrangements are made and it is picked up by a parent or designee.

Parent/Guardian Signature	Home Phone	Work Phone	Date

Physician Authorization

ONE MEDICATION PER FORM

Name of Medicine		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)		Date
Physician's Signature		

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

NO MEDICATION WILL BE ADMINISTERED WITHOUT THESE REQUIRED SIGNATURES.

Date Medication Received_____Amount Received_____Label/orders match (initial)_____
Signature of Person Delivering Medication_____Signature of person receiving Medication_____

Date Medication Received_____Amount Received_____Label/orders match (initial)_____
Signature of Person Delivering Medication_____Signature of person receiving medication_____