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 from 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.