**MADERA UNIFIED SCHOOL DISTRICT**
**1902 HOWARD ROAD • MADERA CA 93637**

**HEALTH SERVICES**

# AUTHORIZATION TO ASSIST A PUPIL IN TAKING MEDICATION
# AND
# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby request school authorities to assist my son/daughter, (name)

(school) (track) (grade)

in taking the medication indicated below which I shall supply to the school for the duration of its prescription.

**Date:** _____ **Signed:** _____
**Parent or legal guardian**

**Telephone:** _____ **Address:** _____

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**TO PHYSICIAN:** Under certain unusual circumstances, a pupil with a chronic health problem may require medication during school hours in order to participate in the regular program. Your recommendations will be used according to Education code Section 49423 to assist the above pupil in taking a required medication. This authorization will remain in effect for one year.

_____
Signature of school nurse

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Diagnosis or description of chronic health problem: _____

Name, dosage, frequency, and duration of medication under prescription: _____

Side effects which school should be alert for and notify parent and doctor regarding:

Limitations of physical activity: _____

**Date:** _____ _____
**Signature of physician**

**Telephone:** _____ **Address:** _____

May Carry Medication ___Yes___No _____

**N-1020**