Bonita Unified School District
Office of Health Services
Authorization for Medication to be Given During School Hours

Parent Section:

STUDENT'S LAST NAME: ______________________________ FIRST NAME:__________________

SCHOOL NAME:____________________________________ GRADE:_______________________

DATE OF BIRTH: __________________________________ AGE:___________________________

I hereby give my permission for school personnel to give the medication listed below as directed. I also give the school nurse permission to contact the physician regarding the child's reaction to the medication or if there is a change in the child's health status.

Parent/Guardian Signature: _________________________________Date: _____________________

Home Phone: ( ) _______________ Work Phone: ( ) _______________Cell: ( )_______________

Physician Section:

Medical Diagnosis: ____

Medication Name / Generic Name: ____

Dose: ___________________________________Time: _________________________________

How soon can it be repeated? ____

Discontinue date: ____

List significant side effects: ____

Due to the student's health condition of asthma, migraines, and/or anaphylaxis, student must carry medication ***on his/her person:*** ☐ *Yes* ☐ *No* ***(not recommended for elementary aged students)***

Physician's Signature: ____________________________ **Address:** ___________________________

Physician's Name Printed: _________________________ **Date:** ______________________________

Telephone: ( ) ______________________________ **Fax:** ( ) ___________________________

All medication authorizations are good for the current school year only

08/07 rs

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