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