Los Gatos-Saratoga High School District
17421 Farley Road West • Los Gatos, California 95030
(408) 354-2520 • Fax (408) 354-4198

GOVERNING BOARD
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Katherine Tseng
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SUPERINTENDENT
Bob Mistele

In accordance with California Education Code section 49423, this form must be completed by an authorized California healthcare provider and be on file for any student who requires medication(s) during the regular school day.

Student Information:

Last Name	*First Name*	*DOB*	*Grade*

School Name	*School Phone number*	*School Fax*	*School Nurse (if applicable*

TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER:
(California licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants - California Code of Regulations, Title 5, section 601[a]).

For Unlicensed Volunteer School Employee to administer the above medication: The prescribing California Authorized Licensed healthcare provider is delegating the administration of the medication to an Unlicensed volunteer employee who has agreed to administer the medication.

The above named student is currently under my care and receiving medication(s) for the following condition(s):

____

. DRUG:____________________________DOSE:________AMOUNT:___________TIME:_________

ROUTE:____

OBSERVABLE ADVERSE REACTIONS THAT MIGHT BE SEEN AT SCHOOL:

____

MEDICATION WILL CONTINUE FOR: ☐ DAYS ☐ MONTHS ☐ UNTIL:__________

____________________________________ ________________________ ______

Authorized Healthcare Provider Name (print) **Signature** **Date**

______________________________ ________________________

License Number Phone Number **Fax Number**

Parental Authorization

I authorize the credentialed school nurse or other unlicensed volunteer personnel designated by the responsible administrator, to administer the medication as directed by the authorized health care provider. I understand that the school nurse has my permission to communicate with the prescribing licensed health care provider on matters related to this medication.

______________________________ __________________ __________________ ______

Parent/Guardian Name (print) **Signature Daytime** **Phone Number** **Date**

____ ________________________ ____________

Reviewed by Credentialed School Nurse (print) **Signature** **Date**