EL DORADO COUNTY OFFICE OF EDUCATION
6767 Green Valley Road, Placerville, CA 95667
(530) 295-2227

PARENT PERMISSION SLIP FOR ASSISTANCE WITH PUPIL MEDICATION

I desire that a designated school person, pursuant to California Education Code, Section 49423, assist my child, whose name is ______________________, whose date of birth is ______________, and who attends a County Office operated program at ______________________ School, by administering the medication or procedure specified below at school as set forth in the physician's statement below. I authorize school personnel to contact the physician identified below whenever necessary regarding the medication and/or procedures prescribed.

____

Signature of Parent or Legal Guardian Date

PHYSICIAN'S STATEMENT OF REQUIRED PUPIL MEDICATION

______________________________ should be given the following medication:
Pupil's Name

Medication/Procedure	Dose	Method of Administration	Time of Day	Duration

Possible side effects of medication: ______________________________

Medical diagnosis: ______________________________

____

Signature of Physician Date

____

Please print name and affix stamp. Thank you.

____

Address Telephone

C:cs(forms/dr-med)