



**HARVEST CHRISTIAN SCHOOL**  
**Administration of Prescribed Medication for Pupil**  
(Education Code Section 49423)

TO: \_\_\_\_\_  
(Principal's Name)

1. Physician's Statement

\_\_\_\_\_ is under my professional care  
and is on the following medication:

Medication: \_\_\_\_\_ Current Dosage: \_\_\_\_\_

Method medication is taken \_\_\_\_\_

Date medication to be started \_\_\_\_\_ Date to be ended \_\_\_\_\_

Time schedule \_\_\_\_\_

Precautions, if any \_\_\_\_\_

I recommend that the school nurse or other designated school personnel assist in the  
administering of the prescribed medication during school hours.

Date: \_\_\_\_\_ Signature of Physician: \_\_\_\_\_

2. Parent(s) or Guardian Statement:

As the parent(s) or guardian of \_\_\_\_\_  
(Student's Name)

(we) (I) request Harvest Christian School assist in carrying out \_\_\_\_\_  
(Physician's Name)  
instructions in the administering of the prescribed medication during the school day.

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

**NO MEDICATION WILL BE ADMINISTERED WITHOUT THE SIGNATURES OF  
THE PHYSICIAN AND PARENT/GUARDIAN**

(Please return this form to the school office)

**Note:** When possible medication should be administered outside of the school day. The school should be requested to assist the child with medication only in exceptional cases when the child's health condition requires medication during the hours school is in session.