



האקדמיה היהודית סן-דייגו  
The pluralistic community day school

## Authorization for Medication Administration (Education Code Section 494423)

I, the undersigned, as legal parent/guardian of \_\_\_\_\_(Student)  
\_\_\_\_\_ (Teacher), \_\_\_\_\_(Grade) attending San Diego Jewish  
Academy, request that the following medication(s):

\_\_\_\_\_

be made available to my child.

I understand that only personnel authorized by the school principal will assist my child in taking the medication as directed by my physician. I authorize school personnel to contact my physician as needed.

I will provide the medication in the prescription container(s) which is labeled with the name of my child, the prescribing physician, and the amount of medication to be given.

I understand that if any of the conditions in the Physicians statement change, a new form must be signed by the parent/guardian and the physician.

I recognize the fact that this is a service or accommodation  
Which the school is not legally required to perform. I agree to  
Save and hold the school, its employees or agents harmless from  
liability suites or claims, or whatever nature or kind, which might  
arise as a result of administering the medication  
In accord with this request.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Home Phone

### TO BE COMPLETED BY PHYSICIAN LICENCED IN THE STATE OF CALIFORNIA

Name of Medication	Method of Administration	Dosage	Appx. Time
#1 _____	_____	_____	_____
#2 _____	_____	_____	_____

TYPE OF ASSISTANCE REQUIRED (Observe, Measure, etc)

\_\_\_\_\_  
Printed Name of Physician

\_\_\_\_\_  
Medical License Number

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date