



2026 Medication Form

Required for Resident and Day Students taking medication at Ojai Valley School

STUDENT NAME: _____ DOB: _____ Fall Grade: _____

In accordance with California Education Code section 49423, all students receiving medication at school require a medication authorization which must be completed by a California licensed physician or other healthcare provider who has the authority to prescribe medication in the state of California. The information requested on this form is necessary to comply with the law and to insure adequate protection of the students.

Requirements:

- 1. All supplements, medicated ointments, over-the-counter or prescribed medications are considered "medication" at Ojai Valley School.
- 2. All medication must come in its original packaging with manufacturer label or pharmacy label in English. Expired medication cannot be dispensed.
- 3. I request that the student be allowed to SELF-ADMINISTER/CARRY medications, such as asthma rescue inhaler/epinephrine injector, diabetes supplies/insulin, or hormonal contraception while at Ojai Valley School with a Healthcare Provider's signature. I waive any claims/damages/causes of action if they suffer adverse reaction or injury out of self-administration. I agree that Ojai Valley School and its employees are to incur no liability as a result of any injury/personal harm arising from the student's medication self-administration. Self-carry medications must be checked in with the Health Center, prior to self-carry.

Parent Authorization for Dispensing Medication

I request that student be dispensed medication in accordance with the information below by a member or the Ojai Valley School staff. I must notify Health Center staff if the medication is to be changed or stopped and provide a new medication form with any changes. I understand that Ojai Valley School is not legally obligated to dispense medication to student/camper; therefore, I hold Ojai Valley School and its employees free from any and all suits, which might arise out of these arrangements.

Parent/Guardian Name: _____ Signature: _____
Phone #: _____ Date: _____

PROVIDER SECTION: TO BE COMPLETED BY PHYSICIAN

Diagnosis/Condition _____ Discontinue Medication 1 (date) _____

Medication	_____	Dose:	_____
Method of Administration:	_____ Time to be given: _____	Frequency:	_____
Self Carry	_____ Possible side-effects: _____	Route:	_____

Diagnosis/Condition _____ Discontinue Medication 2 (date) _____

Medication	_____	Dose:	_____
Method of Administration:	_____ Time to be given: _____	Frequency:	_____
Self Carry	_____ Possible side-effects: _____	Route:	_____

Diagnosis/Condition _____ Discontinue Medication 3 (date) _____

Medication	_____	Dose:	_____
Method of Administration:	_____ Time to be given: _____	Frequency:	_____
Self Carry	_____ Possible side-effects: _____	Route:	_____

Healthcare Provider Section (Signature or Stamp)

Healthcare Provider's Name: _____
Address: _____
Signature: _____
Phone #: _____

Healthcare Providers Signature: _____ Date: _____