PHYSICIAN'S STATEMENT

This portion to be completed by pupil's school personnel

Name of Pupil _____Birth date _____

Last First Middle Month Day Year

School _____Teacher _____ Grade ____

This form valid only for school year 20 ___ to 20___

Location of medication (Building, Room Number, Cabinet) _____

Type of container _____

Person(s) authorized to assist pupil (nurse, health tech, secretary, self)_____

Who is to bring medication to school? (Name of person) _____

How often will medication be brought to school? (Daily, weekly, etc.) _____

The front side of this form must be signed by parent before returning to school

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This portion to be completed by a physician licensed in the State of California

1. Name of Medication Method of Administration Dosage Approx. time of day

#1 _____ _____ _____ _____

#2 _____ _____ _____ _____

1. Discontinue Medications #1 on _____ and Medication #2 on _____

2. Type of assistance for administering medication (observe, measure, etc.) _____

_____

3. Precautions for administration or storage of medication: _____

_____

4. Do you wish to have school personnel contact you at intervals to discuss this medication?

_____ Yes _____ No

Please indicate: Person(s) _____ Intervals _____

Teacher, Nurse, Psychologist, Etc. Daily, Weekly, Quarterly, etc.

_____M.D. _____ _____

Printed Name of Physician Medical License Number Telephone Number

_____ _____

Signature of Physician Date

AUTHORIZATION FOR MEDICATION ADMINISTRATION

(Education Code Section 49423)

Any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by a school nurse or other designated school district personnel if the district receives:

1. A written statement from a physician licensed in the State of California detailing the method, amount, and time schedules by which such medication is to be taken. *See the reverse side of this form.*

2. Written authorization from the parent/guardian of the pupil indicating the desire that school district personnel assist the pupil in the matters set forth in the Physician's Statement. *See authorization statement below.*

This authorization is valid only for the current school year. If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Only medication prescribed by the pupil's physician, as being necessary to be taken by the pupil in the manner listed on the Physician's Statement should be brought to the school. Medication should be in containers that are clearly marked with the name of the pupil, the name of the prescribing physician, name of the medication, and the amount of medication.

This portion to be completed by parent/guardian.

I request that a school nurse or other district designee administer the medication as directed by the physician on the reverse side of this form to my child:

Pupil's name: _____

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

_____ _____

Signature Date

_____ _____

Work Telephone Number Home Telephone Number