PHYSICIAN'S STATEMENT

This portion to be completed by pupil's parent/guardian.

Name of Pupil _____ Birth Date _____
Last First Middle Month Day Year

_____ _____ _____ _____
School Teacher Room Grade

This form valid only for one school year beginning _____. (September 1st to August 31st)

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

Type of Container _____

Person(s) authorized to Assist Pupil (Health Clerk, Aide, Secretary, Self) _____

The other side of this form must be signed by parent/guardian before returning to school.

1.	Name of Medication	Method of Administration	Dosage	Specific frequency (if prn, i.e. q 6 hrs.)
#1	_____	_____	_____	_____
#2	_____	_____	_____	_____

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

3. Type of Assistance for Administering Medication (Observe, Measure, etc) _____

_____

4. Precautions for Administration or storage of Medication. _____

_____

5. 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 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 physician and the parent/guardian.

An **adult** must bring only the 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 to the school. Medication must be in containers which are clearly marked with the name of the pupil, the name of the prescribing physician, name of the medication and the amount of medication dose**. No envelopes or plastic bags!**

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:

For medication to be given at school on an ***as needed*** basis and to avoid your child receiving doses too close together call the health office at the school site to ***notify her if your child received that medication prior to school that day.*** If your child attends CARE, you will also need to notify them ***in addition*** to the school site.

_____
Pupil's Name

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 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 of Parent/Guardian Date

_____ _____
Work Telephone Number Home Telephone Number