REQUEST FOR MEDICATION IN SCHOOL

Student: _____ Grade: ___ Birth-date: _____

Education Code 49423: Notwithstanding the provisions of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

WHENEVER POSSIBLE, MEDICATION SHOULD BE GIVEN AT HOME, BEFORE AND AFTER SCHOOL, PROVIDING THIS MEETS WITH THE PHYSICAN'S APPROVAL.

PARENT/GUARDIAN STATEMENT:

(I) I am the parent/guardian of the pupil named above. I am giving permission to and requesting school district personnel to assist this student with medication as prescribed by the physician.

(II) The medication will be sent in the original prescription container with the pharmacy label stating physician's complete instructions for administering the medication.

(III) The school and the physician may exchange information regarding the student's medication and medical condition.

(IV) (I)(We) the parent(s) of the above-named student, hereby indemnify and hold harmless from any demands, claims, actions, suits, or any nature or kind, any and all personnel, employees and agents of said district who may act pursuant to the above instructions or pursuant to the instructions of the child's physician.

_____ _____

Signature of Parent or Legal Guardian Date

PHYSICIAN'S STATEMENT:

The above named student is currently under my care and is receiving medication(s) for the following condition(s):

_____

_____

_____

MEDICATION(S) TO BE ADMINISTERED AT SCHOOL DURING SCHOOL HOURS:

1. Drug _____ Dose _____ Amount _____
   Time: _____ Method _____
   Adverse reactions: _____

2. Drug _____ Dose _____ Amount _____
   Time: _____ Method _____
   Adverse reactions: _____

_____ _____

Physician's Signature Date

PLEASE PRINT: Name _____
Address _____
Telephone _____