Orange Unified School District
PARENT AND PHYSICIAN REQUEST FOR MEDICATION

Name of Pupil ______________________ **Birthdate** ______________
Address ______________________ **Telephone** ______________

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION (Prescription and Non-Prescription)

California Education Code 49423 and School District policy permits the administration of medication by designated school personnel. This service is provided when medication: 1) Is required during the school day, 2) Enables a child to remain in school, 3) Assists in maintaining or improving a child's potential for learning.

I request that medication be administered to my child,__________________, in accordance with our physician's written instructions. This includes my agreement/understanding that: 1) Designated school personnel will administer medication under supervision of a qualified School Nurse; 2) The school will be notified immediately of all changes in medication, dosage, time of administration, and/or the prescribing physician; 3) Permission is granted for the physician to be contacted when needed to clarify instructions; and 4) Information on other side has been reviewed by me.

Parent Signature______________________ **Date**______________

PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION (Prescription and Non-Prescription)

Diagnosis/Reason for Medication:______________________

Medication*______________Dose______________Route__________Time__________

Medication*______________Dose______________Route__________Time__________

* If given PRN, specify time between doses__________Maximum # of doses per day__________

Possible serious reactions______________________

For Epi-Pen and Albuterol Inhalers only: Student May or May not carry on person.
Disposition of pupil following administration of medication (i.e. rest, home, doctor's office, hospital, return to class):______________________

Date to Start Medication at School__________**Date to Discontinue Medication at School**__________

The above medication cannot be scheduled for other than during school hours and may be administered by designated, non-medical school personnel under supervision of a qualified School Nurse.

Physician Signature______________________

Address/City/Zip______________________

Date of Authorization__________**Telephone**__________

Physician Fax #__________

Please Validate with Office Stamp (REQUIRED)

Medication procedure and written physician/parent authorization have been verified by the School Nurse.

School Nurse Signature______________________**Date**______________

THIS REQUEST IS VALID ONLY FOR THE CURRENT SCHOOL YEAR

Please fax medication form to: ATTN – Health Office. The school's fax number is (714) 628-0381