Spreckels Union School District
P.O. Box 7362
Spreckels, California 93962
Tel: (831) 455-2550
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www.spreckelsunionsd.org

Eric Tarallo, Superintendent

REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

The Board of Education recognizes that certain students may need to take prescribed or over the counter medication during the school day. The Health Clerk, or other persons designated by the Superintendent, shall assist such students in taking their medication. The following statements are **REQUIRED** before such assistance is given:

1. A **written** statement from the student's physician detailing the method, amount and time schedules for taking of the medication.

2. A **written** statement from the student's parent/guardian requesting the District assists the student in taking the prescribed and/or over the counter medication.

PARENT/GUARDIAN REQUEST

Student_____ **Birth Date**_____
Last Name **First** **Middle**

School_____ **Grade**_____ **Age**_____

I (parent/guardian) request that medicine be administered to the above named student in accordance with my physician's instructions noted on the Physician's Request (see other side of this request) by the School Nurse or other designated school personnel.

_____ _____
Parent/Guardian Signature **Date**

Telephone Number _____ _____ _____
Home **Work** **Cell**

The supply of medication sent to school must contain the name and telephone number of the pharmacy, student's name, name of physician and dosage of medication to be given. Original containers are preferred.

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Student's Name_____

Diagnosis or indication for medication: _____

_____

_____

Precautions, if any: _____

Possible side effects: _____

_____

Name & Dose of Medication	Form: Tablets, Capsules, Liquid, Other:	# To Be Taken	Approximate Time of Day

Medication delivered by inhalers may be carried by student **Yes_____** **No_____**

I would like to have a follow-up report, by telephone, with the nurse. **Yes_____** **No_____**

At intervals of: **Daily _____ Weekly _____ Monthly _____ Quarterly _____**

IMPORTANT: Please discontinue this request as of _____
Date **Other Instructions**

(after this date, a new form must be competed for changes or new orders)

PHYSICIAN'S NAME (TYPED OR PRINTED) _____

ADDRESS: _____
Street **City** **Zip**

TELEPHONE NUMBER: _____

PHYSICIAN'S SIGNATURE_____ **DATE**_____

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