

STUDENT HEALTH SERVICES

SCHOOL SITE: \_\_\_\_\_ FAX: \_\_\_\_\_

PHYSICIAN'S RECOMMENDATION FOR MEDICATION

This form is to be filled and signed by a licensed physician. The form should then be signed by the parents or guardians and returned to the school.\*

Pupil's Last Name	First	Middle	Age	Birthdate
Name of School		Telephone/Fax		Grade

The law allows any person to assist in carrying out a physician's recommendations. The school recognizes the desirability of following a physician's recommendations as nearly as possible at school, just as does a parent at home or any other person (not necessarily a nurse) if the physician requests his assistance. The fact that this is a service or accommodation which the school is not legally required to perform is recognized by all parties signing this form, and in so signing they agree to hold the district, employees or agents, harmless from all liability, suits, claims, of whatever nature of kind, which might arise out of these arrangements.

Do you wish this child to receive medication at school? Yes  No

Do you wish the child to carry the medication with him/her? Yes  No   
If yes, please fill in the following blanks:

Name of Medication	Form (tablet, pill, capsule, etc.)	Number to be taken	Approximate Time of Day	Observed or Assisted by Whom (self, teacher, nurse, etc.)
(1) _____	_____	_____	_____	_____
(2) _____	_____	_____	_____	_____

Precautions if any: \_\_\_\_\_

How is medicine to be brought to school: \_\_\_\_\_

By whom (pupil, parent, etc.)? \_\_\_\_\_

How often (daily, weekly, etc.)? \_\_\_\_\_

In what kind of container (envelope, bottle, plastic container)? \_\_\_\_\_

Does the physician wish to be able to talk briefly by telephone with someone (teacher, nurse, principal, psychologist) at intervals (weekly, monthly, quarterly) to see how this child is faring? If so, indicate:

person(s) \_\_\_\_\_ and intervals \_\_\_\_\_ and you will be notified as to numbers and times at which the person(s) may usually be reached at school by telephone.

**IMPORTANT:** Please discontinue this request as of the following date: \_\_\_\_\_  
Mo. / Day / Yr.

After this date, changes or continuance of these arrangements must be secured by filling out a newly dated copy of this form.

Signature	California Medical License No.	Address	Telephone	Date
**Parents or guardian's full name				Date
**Parents or guardian's full name				Date

\*See reverse side for legal provisions and suggestions for school procedures.

\*\*Signatures of both parents or guardians are necessary if they are living with or having custody of the child.