Request of School Personnel to Assist In the Administration of Medication

Burchfield Primary School FAX (530) 458-8874
Egling Middle School FAX (530) 458-8107
Colusa High School FAX (530) 458-5783
Colusa Alternative High School FAX (530) 458-4070

ADMINISTRATION OF PRESCRIBED MEDICATION FOR PUPIL (CA. Ed. Code 49423):

"Not withstanding the provisions of Section 476423 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." (Added by Stats. 1968 CH. 681)

1. TO BE COMPLETED BY THE PARENT/GUARDIAN

Name of pupil: _____ BD: _____ Age: _____
Address: _____ Phone: _____

I hereby request that AUTHORIZED school personnel assist the above named pupil in the taking of the medication indicated in the manner and dosage prescribed by:

NAME OF PHYSICIAN: _____

Parent/Guardian Signature: _____ Date: _____

Name of Parent/Guardian: _____
Address: _____
Telephone: _____

2. TO BE COMPLETED BY PHYSICIAN

Name of Medication: _____
Form (tablet, liquid, inhaler, injection): _____
Dosage: _____ Schedule of Doses: _____
Date of Discontinuance: _____
Restrictions/Cautions/Possible Side Effects:
_____
_____

The data herein concerning the medication for the above named student is to be used only by the person designated by the school administration to assist in the taking of the medication. It is my understanding that this medication may be taken during the school day by the student designated herein and the student may be assisted by the person(s) designated by the school administration.

Physician's Signature: _____ Date: _____
Physician's Name (typed or printed): _____
Address: _____
Telephone: _____

3. TO BE COMPLETED BY SCHOOL PERSONNEL

Person(s) designated by school administration to assist the student in taking medication:
_____
School Official making this designation: _____ Date: _____