Medication Required During School Hours/Day Field Trips

School Year_____

HEALTH SERVICES - LINDA LENOIR, R.N., MSN 650-329-3766
PALO ALTO UNIFIED SCHOOL DISTRICT
25 Churchill Avenue • Palo Alto, CA 94306

SCHOOL_____ SCHOOL FAX_____

THIS FORM MUST BE COMPLETED BEFORE ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATION CAN BE ADMINISTERED AT SCHOOL

Student Name: _____ Grade/School: ____/_____

It is the practice of the Palo Alto Unified School district to prohibit students carrying medications while at school or to and from school. (Exceptions will be made when the PHYSICIAN believes that a life-threatening situation could result if the student does not have immediate access to the medication.)

TO BE COMPLETED BY PHYSICIAN FOR BOTH EPISODIC AND NON EPISODIC MEDICATIONS. CONTROLLED MEDICATIONS MAY NOT BE CARRIED

Diagnosis: _____
Please Print Clearly

Drug	Dose	Route	Time	Special Instructions/ Precautions	Location at School: Health Office	Student Carry	Home Room
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

☐ I give permission for trained staff to assist in administration of medications listed above.

☐ I give permission for student to carry and self-administer medication checked above. The health care provider has confirmed that the student is capable of appropriate self-administration of the above medication. If student is younger than 18, the parent/guardian assumes all liability related to this patient's use, timing and technique in self-administering this medication.

Physician Signature _____ Date: _____

Physician Name (print) _____

Office Phone: _____ **FAX:** _____

Office Stamp

TO BE COMPLETED BY PARENT/GUARDIAN:

☐ I request that my child be allowed to take medication at school according to the instruction from his/her physician. I understand it is my responsibility to **bring the medication to school in the original pharmacy container labeled with the child's name, medication, dosage and directions** (Ed Code 49423). Determination of the request will be reviewed by the School Nurse

☐ I authorize the school personnel to assist with the above medication for my child as ordered by the physician listed above. I understand that trained, non-medical school personnel may assist with this medication. (Ed Code Sec 49423 and 49480)

While the school will make every effort to cooperate, the child must assume responsibility for coming to the office for his/her medication.

This form must be renewed whenever the prescription changes and at the beginning of each school year.

Parent/Guardian Signature: _____ Date: _____

Home Address: _____

Daytime Phone Numbers: _____ (Home) _____ (Business) _____ (Cell)

STUDENT CONTRACT FOR CARRYING OWN MEDICATION: I _____ will be responsible for carrying, administering and keeping safe, at all times, my medication. I will use the medication in the way prescribed by my physician. I will not show or share my medication with others students. I will immediately report to persons in charge if my medication is missing.

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