Redlands Unified School District

Health Services

PHYSICIAN'S RECOMMENDATIONS FOR MEDICATION AT SCHOOL
(Prescription and/or over the counter)

Student's Name:_____ Birth Date: _____

School: _____ Date: _____

The California Education Code relating to assisting with medications at school states:

49423, notwithstanding the provisions of Section 49422, 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.) 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 matter set forth in the physician's statement.

The Redlands Unified School District has implemented this policy. The information requested on this form is necessary to comply with the law and to insure adequate protection for pupils.

TO BE COMPLETED BY A CALIFORNIA LICENSED PHYSICIAN

If this is an injectable medication (i.e. epi-pen, glucagon, insulin) please have parent call Health Services at 307-5300 for the appropriate paperwork

A. **Nature of the condition** requiring medication(s) during the regular school day:

_____

B. NAME OF MEDICATION(S) / METHOD OF ADMINISTRATION / DOSAGE / APPROX. TIME OF DAY

1. _____ _____ _____ _____

2. _____ _____ _____ _____

C. Discontinue Medication No. 1 on _____; discontinue Medication No. 2 on _____
Date Date

D. Side effect/Precautions if any: _____

E. If medication procedure changes in any way a new form must be completed. This form needs to be renewed at the beginning of every school year.

Please have an **adult** deliver the medication(s) and completed form to the school

_____ _____ _____ _____
Physician's Signature License No. Telephone Month/Day/Year

_____
Print Name (Physician)

I agree with the above and hereby give my permission for school personnel to assist my child in taking the above medication(s) as directed. I also give the district nurse permission to contact the physician regarding my child's reaction to the medication(s), or if there are changes in my child's health status.

_____ _____ _____
Parent/Guardian's Signature Telephone Month/Day/Year