

School Phone # \_\_\_\_\_  
School Fax # \_\_\_\_\_

## PHYSICIAN INSTRUCTIONS

For SCHOOL ASSISTED MEDICATION

**A.** This form must be completed before any medication (*prescription or over-the-counter*) can be given, or taken, at school. *Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.*

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

<b>PHYSICIAN USE ONLY</b>	
<b>1. MEDICATION:</b> _____	<b>Dose:</b> _____ <b>Reason/Diagnosis:</b> _____
Route: <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Topical <input type="checkbox"/> Inhale <input type="checkbox"/> Injection <input type="checkbox"/> Other _____	<b>Med Start Date:</b> _____ <b>Stop Date:</b> _____
<input type="checkbox"/> If DAILY ~ Time(s) to be given: _____	
<input type="checkbox"/> If AS NEEDED (prn) ~ Frequency: <input type="checkbox"/> Every 3 to 4 hrs., <input type="checkbox"/> Every 4 to 6 hrs., <input type="checkbox"/> Other _____	
<input type="checkbox"/> *Self administered – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence. <ul style="list-style-type: none"> <li><input type="checkbox"/> (Not recommended in elementary school)</li> </ul>	
Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____	
<b>2. MEDICATION:</b> _____	<b>Dose:</b> _____ <b>Reason/Diagnosis:</b> _____
Route: <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Topical <input type="checkbox"/> Inhale <input type="checkbox"/> Injection <input type="checkbox"/> Other _____	<b>Med Start Date:</b> _____ <b>Stop Date:</b> _____
<input type="checkbox"/> If DAILY ~ Time(s) to be given: _____	
<input type="checkbox"/> If AS NEEDED (prn) ~ Frequency: <input type="checkbox"/> Every 3 to 4 hrs., <input type="checkbox"/> Every 4 to 6 hrs., <input type="checkbox"/> Other _____	
<input type="checkbox"/> *Self administered – for asthma inhaler or epinephrine auto-injectors ONLY. Student demonstrates competence. <ul style="list-style-type: none"> <li><input type="checkbox"/> (Not recommended in elementary school)</li> </ul>	
Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____	
<b>Physician Signature:</b> _____	<b>Date:</b> _____
<b>Physician Name:</b> _____	
<b>Address:</b> _____	<b>Phone:</b> _____
<b>City:</b> _____	<b>Zip:</b> _____

**All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.**

California Education Code section 49423 provides that 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.

\* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

## Parent Request For Assistance with Medication at School

**B.** The parent or guardian must complete this page before any medication (*prescription or over-the-counter*) can be given, or taken, at school.  
**Signature of parent or guardian is required. This form must be renewed each school year or with any change in medication.**

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

### Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

**A.** I hereby request that the staff of my child's school assist in giving medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**B. For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTORS SELF-administered only:** I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication.\* I also give permission to contact the physician for consultation and exchange of information as needed.

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

### Student Contract – Asthma Inhalers Only

I agree to keep my medication in a safe and secure place, such as on my person, at all times. I agree I will NEVER share my medication with another student. If I am using my inhaler more than once a day, I will speak with the school nurse.

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year.**

\* California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.