



Orange County Department of Education
Instructional Services

Parent /Guardian and Physician Request for Medication

Name of Pupil: _____ Birthdate: _____ District/School: _____
Address: _____ Room: _____ Grade: _____

**PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NONPRESCRIPTION**

California Education Code Section, 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child, _____, in accordance with our physician's written instructions. I understand that designated school personnel will administer medication under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing physician and give permission to contact the physician when necessary.

Parent/Guardian Signature: _____ Date: _____
Telephone: (Work) _____ (Home) _____

Medication must be in the student's original, labeled pharmacy container. You may request from your pharmacist, two containers, one for school and one for home.

PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION

Diagnosis/Reason for Medication: _____

Medication: _____ Dose: _____ Route: _____ Time: _____

If PRN: Amount of time between doses _____ Maximum number of doses _____ per day:

Possible reactions: (possible serious reactions with this medication i.e., allergic reaction, localized/general, etc.)

Instructions for emergency care: _____

Disposition of pupil following administration of medication.

Circle one: (Rest • Home • Doctor's Office • Hospital • Return to Class.)

The above medication cannot be scheduled for other than during school hours and this medication may be administered by non-medical school personnel under the supervision of a qualified School Nurse.

Physician's Signature: _____
(Please use office stamp)

Address: _____ Telephone: _____

Date of Request: _____ Date To Discontinue Medication: _____

This request is valid for a maximum of one year

SCHOOL USE:

Nurse: _____ Date: _____

Administrator: _____ Date: _____