CAJON VALLEY UNION SCHOOL DISTRICT

# Physician's Recommendation for Medication

Student Name: _____

School: _____ Grade: _____ DOB: _____

**TO BE COMLETED BY LICENSED PHYSICIAN**

| | Medication | Method of Administration | Dosage | Time/Frequency | Condition |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |

Example:

| | | | | |
|---|---|---|---|---|
| Medication Name | Oral | 40 mg | Daily/noon | ADHD |

Medication side effects: _____

| Health Care Provider Information | |
|---|---|
| **Signature:** _____ | **Date:** _____ |
| Name (Print): _____ | Address: _____ |
| Phone: _____ | Fax: _____ |

I, as parent/guardian request that the medication(s) be made available to my child at the times prescribed. I authorize the District Nurse or other designated school personnel to contact my child's physician and pharmacist regarding this recommendation. I will provide the medication(s) in the prescription container(s) which is labeled with my child's name, the prescribing physician's name, the dosage, times to be given and monitoring devices (if needed). I will notify the District Nurse or other designated school personnel if there is a change to the child's medication, health status or authorized health care provider.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Parent/Guardian Signature | Home #: | Cell #: | Date: |

*California Education Code 49423.1 (a) Notwithstanding Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him or her by a physician or surgeon, may be assisted by the school nurse or other designated school personnel or may carry and self-administer inhaled asthma medication if the school district receives the appropriate written statements specified in subdivision (b).*

*(b) (1) In order for a pupil to be assisted by a school nurse or other designated school personnel pursuant to subdivision (a), the school district shall obtain both a written statement from the physician or surgeon detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken and a written statement from the parent, foster parent, or guardian of the pupil requesting that the school district assist the pupil in the matters set forth in the statement of the physician or surgeon.*

District Nurse Signature: _____ Date: _____