

WILLIAM S. HART UNION HIGH SCHOOL DISTRICT

21515 Centre Pointe Parkway, Santa Clarita, CA 91350-2948 Phone 661 259-0033 Fax 661 254-8653

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

To the Physician: Please complete and sign this form if medication prescribed for a school-age child must be given during school hours to prevent serious physical or behavioral problems. Prescribed medication includes over-the-counter medication. It is a request and guide to authorized school personnel to assist the student with medication.

Rio Norte Jr High School

661 295-3700

X1124

661 257-1413

School

School Phone Number

Health Office Extension

School Fax Number

Last Name of Pupil

First Name

Sex

Grade

Date of Birth

PHYSICIAN / SURGEON TO COMPLETE THE FOLLOWING:

Purpose of Medication or Diagnosis

Name of Medication

Prescribed Dosage

Time Schedule

Dose Form (tablet or liquid)

Date of Prescription

Length of Time this Medication will be necessary

PRECAUTIONS, SPECIAL RECOMMENDATIONS OR INSTRUCTIONS:

POSSIBLE SIDE EFFECTS: Sleepiness Dizziness Stumbling Irritability Nausea
 Staggering Vomiting Thirstiness Frequent Urination

The student for whom this medication is prescribed is under my care.

PRINT Name of Licensed Physician / Surgeon

SIGNATURE of Licensed Physician / Surgeon

DATE

Physician's / Surgeon's Address

Phone Number

Fax Number

NOTE: Medication given at home may also modify learning behavior. Therefore, we request information regarding any physician-prescribed medication given at home.

The medication listed below is prescribed for this child to be taken only before 8:00 a.m. or after 3:00 p.m.

Medication: _____

Purpose: _____

Beginning Date: _____

Ending Date: _____

PARENT / GUARDIAN TO COMPLETE THE FOLLOWING:

I request that my student, _____, be assisted in taking the above prescribed medication at school by authorized persons. I will comply with the school's policies and procedures. I agree to, and do hereby hold the District and its employees harmless from any and all claims, demands, causes of action, liability or loss of any sort because of, or arising out of the acts or omissions of the District or its employee's with respect to this medication. In signing this document I specifically acknowledge that I am aware that assistance in receipt of prescribed medication may be given by the school nurse, the health assistant, or other designated school personnel.

Emergency medical services may be called when a licensed nurse is not on site and medication is required to be administered by such a person.

Signature of Parent / Guardian

Date

Home Address

City

State

Zip Code