CENTRAL VALLEY HOME SCHOOL
1776 6th Avenue Drive
Kingsburg, CA 93631
(559) 897-6740 FAX (559) 897-6872

MEDICATON AT SCHOOL

CHILD'S NAME ___________________________Birthdate________

PARENT'S NAME____

Dear Parent:

Education code section 49423, 49423.6, and 49423.1 defines certain requirements for administration of medication, "…*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 matter set forth in the physician's statement."*

The medication must be clearly labeled and sent to school in the container from the pharmacy.

A new "MEDICATION AT SCHOOL" form must be provided annually or if there is a change in the health care provider, medication, dosage, method or time medication is required to be taken.

PARENT'S REQUEST

We the undersigned, who are parents/guardian of ________________________________request that the school nurse or designated school personnel assist the pupil in matter set forth by the physician's statement. In the event of an untoward or subsequent reaction it is understood that they, as school personnel, will in no way be held responsible for carrying out this request. Parent may at any time submit a written statement rescinding parent consent for administration of medication at school. We give permission to the school nurse and physician/agency to disclose and discuss information.

Date: ______________________ *Signature of Parent/Guardian* ______________________________________

PHYSICIAN'S ORDERS

Medication	Dose	Route	Time(s) To Be Given

1. Diagnosis or Reason for Medication ____

   ____

2. Time limit on medication (i.e. 10 days, 1 month, etc.) ____

3. For ASTHMA INHALERS & EPI-PENS ONLY:
   1. Child may carry inhaler and self medicate Yes No
   2. Child to have self-paced PE Yes No

Date: ______ *Telephone Number* __________ *Physician's Signature* ___________________________________
*Physician's Address*_____________________ *Physician's Name* *(please print)*______________________________

For additional information, please call the school.

____________________________________ ______________
School Nurse Date