

\_\_\_\_\_ School District  
**REQUEST FOR MEDICATION IN SCHOOL**

Education Code 49423: Notwithstanding the provisions of Section 49422, 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.

WHENEVER POSSIBLE, MEDICATION SHOULD BE GIVEN AT HOME, BEFORE AND AFTER SCHOOL, PROVIDING THIS MEETS WITH THE PHYSICIAN'S APPROVAL.

**PARENT/GUARDIAN STATEMENT:**

- (I) I am the parent/guardian of the pupil named above. I am giving permission to and requesting school district personnel to assist this student with medication as prescribed by the physician.
- (II) The medication will be sent in the original prescription container with the pharmacy label stating physician's complete instructions for administering the medication.
- (III) The school and the physician may exchange information regarding the student's medication and medical condition.
- (IV) (I) (We) the parent(s) of the undersigned student, hereby indemnify and hold harmless from any demands, claims, actions, suits, or any nature or kind, any and all personnel, employees and agents of said district who may act pursuant to the above instructions or pursuant to the instructions of the child's physician.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Date of Birth

**PHYSICIAN'S STATEMENT:**

The above named student is currently under my care and is receiving medication(s) for the following condition(s):

**MEDICATION(S) TO BE ADMINISTERED AT SCHOOL DURING SCHOOL HOURS:**

1. Drug \_\_\_\_\_ Dose \_\_\_\_\_ Amount \_\_\_\_\_  
Time: \_\_\_\_\_ Method \_\_\_\_\_  
Adverse reactions: \_\_\_\_\_

2. Drug \_\_\_\_\_ Dose \_\_\_\_\_ Amount \_\_\_\_\_  
Time: \_\_\_\_\_ Method \_\_\_\_\_  
Adverse reactions: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

PLEASE PRINT:

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_