Arcadia Unified School District
Student Health Services
150 S. Third Avenue, Arcadia, CA 91006
Telephone: (626) 821-1731 ··· Fax: (626) 821-1712

Physician's Recommendation for Medication
(To be completed by Physician)

_____ ____ _____ _____ _____
Name of Pupil (last, first, middle) Age Birthdate Grade School

Do you wish this child to receive medication at school? Yes: _____ No: _____ (If yes, please complete the table below)

PLEASE request that the pharmacy provide the school with a properly labeled container for medications
****For PRN medications-include allowable frequency for the medication and explain when a medical referral should be made**

Name of Medication	Med Form *(liquid, tab, etc)*	Dose *(mg, ml)*	Time to be taken	Medical Condition	Special instructions

I, the undersigned, as the physician of the above named pupil, confirm that he/she is under my care for the above named conditions.

Name of Physician (Printed): _____ Phone: _____

Address: _____

License Number: _____ Signature of Physician: _____

If above prescribed medication is a self-administered medication (auto-injectable epinephrine and/or asthma inhaler ONLY)
Do you prefer that this child carry the medication while at school? Yes: _____ No: _____

In the case of recommending self-administered medications (auto-injectable epinephrine and asthma inhaler ONLY), I confirm that the above named pupil has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of self-administration of the prescribed medication. I understand that there will be no direct monitoring for self-administered medication and the student is responsible for medication administration.

Signature of Physician: _____

I request that my child (the above named pupil) receive the above prescribed medication at school assisted by authorized persons, and will comply with the policies and procedures of the school. I acknowledge that I understand how the authorized persons will administer/assist my child with the above medication. I give my consent for the school nurse to communicate with the supervising physician and to counsel with school personnel regarding the possible effects of the above medication. I understand that I have the right to terminate consent of medication administration at any time.

_____
Signature of Parent/Guardian Print name of Parent/Guardian Daytime Phone Number/s Date

PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE

Required Medication Procedure for Use during School Hours

1. Present a written statement from the student's physician detailing the method, amount, and time schedule for taking the medication including self-administered medication. This includes prescribed, over-the-counter, and herbal medication.
2. Present a written statement from the student's parent/guardian requesting the District to assist the student in taking the prescribed medication including self-administered medication.
3. Parent must bring the medication in the original bottle/box, properly labeled by pharmacy (students *cannot* transport medication). Over-the-counter medication must be in the original box/container.
4. In the case of auto-injectable epinephrine and inhaled asthma medication: the physician must confirm, in writing, that the pupil is able to self-administer the prescribed medication and the parent/guardian of the pupil must complete a written statement consenting to the self-administration and releasing the school district and school personnel from civil liability if the self-administering pupil suffers an adverse reaction as a result of self-administering medication pursuant to this paragraph. Parent will provide an extra auto-injectable epinephrine and asthma inhaler to be stored in the health office as emergency backup.
5. The written statements and authorizations for exchange of information between the school district and the physician must be provided annually and more frequently if the medication, dosage, frequency of administration, or reason for administration changes.

Legal Provisions

California Education Code 49423, 49480 requires that parents of students who need medication during school hours do the following:

EC 49423: provides that 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.

EC 49480: The parent or legal guardian of any public school pupil on a continuing medication regimen for a non-episodic condition shall inform the school nurse or other designated certificated school employee of the medication being taken, the current dosage, and the name of the supervising physician. With the consent of the parent or legal guardian of the pupil, the school nurse may communicate with the physician and may counsel with the school personnel regarding the possible effects of the drug on the child's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects, omission, or overdose. The superintendent of each school district shall be responsible for informing parents of all pupils of the requirements of this section

Permission to Self-Carry Medication

I permit my child to carry the above self-administered prescribed medication as ordered by his/her physician. My child is knowledgeable and capable of self-administration of the medication listed. I understand that sharing any medication with other students and/or failure to comply with the medication administration policy during school hours will result in disciplinary action and permission of self-administration may be revoked. I understand that there will be no direct monitoring for self-administered medication, the student is responsible for self-administration of the medication, and that the student is to report to school staff if symptoms continue or worsen. I will be notified by appropriate school staff if my child continues to have difficulty. I understand it is my responsibility to immediately notify the school if my child's health status changes or when a change in physician and/or medication occurs.

Signature of Parent/Guardian

Print name of Parent/Guardian