



MEDICATION REQUIRED FOR OVERNIGHT FIELD TRIPS / OR IN CASE OF PUBLIC DISASTERS

STUDENT SERVICES – CAROL ZEPECKI, Ed.D. – DIRECTOR,

LINDA LENOIR, R.N., MSN (650) 329-3766

PALO ALTO UNIFIED SCHOOL DISTRICT

FAX (650) 326-7463

25 Churchill Avenue • Palo Alto, CA 94306

THIS FORM MUST BE COMPLETED BEFORE ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATION CAN BE ADMINISTERED BY SCHOOL PERSONNEL

NEEDED FOR MEDICATIONS **REQUIRED DURING NON-SCHOOL HOURS** (I.E. MEDICATIONS THAT MUST BE GIVEN OVER A 24 HOUR PERIOD TO MAINTAIN THERAPEUTIC LEVELS.)

Student Name: _____ Grade/Teacher _____ / _____

School _____ Phone: _____

It is the practice of the Palo Alto Unified School district to prohibit students carrying medications while at school or to and from school. (Exceptions will be made when the **PHYSICIAN** believes that a life-threatening situation could result if the student does not have immediate access to the medication.)

TO BE COMPLETED BY PHYSICIAN FOR BOTH EPISODIC AND NON-EPISODIC MEDICATION. CONTROLLED MEDICATIONS MAY NOT BE CARRIED.
Please Print Clearly

Drug	Dose	Route	Time	Special Instructions/Precautions	Stu. Carry
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

I give permission for student to carry and self-administer medication checked above. The health care provider has confirmed that the student is capable of appropriate self-administration of the above medication. If student is younger than 18, the parent/guardian assumes all liability related to this patient's use, timing and technique in self-administering this medication.

PHYSICIAN SIGNATURE: _____ Date: _____

Physician Name (Please stamp or print): _____

Office Phone: _____ Fax: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I request that my child be allowed to take medication according to instruction from his/her physician. I understand it is my responsibility to bring the medication to school in the original pharmacy container labeled with **my child's name, medication name, dosage and directions for each medication.** (Ed Code 49423)

I authorize the school personnel to administer the above medication to my child as ordered by the physician listed above. I understand that trained, non-medical school personnel may administer this medication. (Ed Code Sec 49423 and 49480)

This form must be renewed whenever the prescription changes and at the beginning of each school year.

Parent/Guardian Signature: _____ Date: _____

Home Address: _____

Daytime Phone Numbers: _____
(Home) (Work) (Cell)

STUDENT CONTRACT FOR CARRYING OWN MEDICATION: I _____ will be responsible for carrying administering and keeping safe, at all times, my medication. I will use the medication in the way prescribed by my physician. I will not show or share my medication with others students. I will immediately report to persons in charge if my medication is missing.