MEDICATION REQUIRED DURING SCHOOL HOURS / FIELD TRIPS / DISASTERS (24-72 Hours) **School Year**_____

Palo Alto Unified School District
25 Churchill Avenue Palo Alto, CA 94306
Health Services Phone 650-833-4240 Fax 650-833-4226

School: _____

School Fax: _____

Student Name:_____ **DOB:** _____

FORM MUST BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER
BEFORE ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATION CAN BE ADMINISTERED

Include:

1. Medications required during school hours

2. Essential medications that must be given outside of school hours, for overnight field trips or in the event of a disaster

3. Medication form must be provided two weeks in advance for field trips (medication/s to be brought to the health office)

TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER CALIFORNIA CODE OF REGULATIONS TITLE 5, SECTION 601(A)

CONTROLLED MEDICATIONS INCLUDING ANTI-DEPRESSANTS CANNOT BE CARRIED BY STUDENT

DIAGNOSIS/REASON	MEDICATION	DOSE	ROUTE	TIME	Medication to be kept in health office. Staff may assist with administration.	Student to carry and self-administer.

If indicated above, I give permission for the above named student to carry and self-administer medication as checked. I have confirmed that the student is capable of appropriate self-administration. If the student is younger than 18, the parent/guardian assumes all liability related to this student's use, timing and technique in self-administering this medication. Other medication/s will be kept and administered accordingly.

Physician Signature: _____ Date: _____

Physician Name (please print): _____

Telephone: _____ Fax: _____ Clinic Stamp Here

TO BE COMPLETED BY PARENT/GUARDIAN

I request that my child be allowed to take medication while at school, on field trips or in case of disaster according to the instruction from his/her physician. I understand it is my responsibility to **bring the medication to school in the original pharmacy container, labeled with the child's name, medication, dosage and directions** (Ed Code 49423). Request to be reviewed by the School Nurse.

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

I give permission for the exchange of information between the prescriber and the school nurse or designee to ensure safe administration of listed medication.

This form must be renewed at the beginning of each school year and whenever the prescription changes.
While the school will make every effort to ensure the student gets their medication on time,
the student must assume responsibility for coming to the office as scheduled.

Parent/Guardian Signature: _____ Date: _____

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

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 other students. I will immediately report to persons in charge if my medication is missing.