



San Diego Unified School District

Nursing and Wellness Program

PHYSICIAN'S RECOMMENDATIONS FOR MEDICATION

Pupil's Last Name	First	Middle	Age	Birth Date: _____ Month/Day/Year
Name of School	School's Fax Number	Name of Teacher	Room No./Grade	

The California Education Code relating to the giving of medications at school states:

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.) 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 San Diego Unified School District has implemented this policy. The information requested on this form is necessary to comply with the law and to insure adequate protection for pupils.

TO BE COMPLETED BY A LICENSED PHYSICIAN

A. **Nature of the condition** requiring medication during the regular school day:

B.	NAME OF MEDICATION	METHOD OF ADMINISTRATION	DOSAGE	APPROX. TIME OF DAY
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

C. Discontinue Medication No. 1 on _____; discontinue Medication No. 2 on _____
Date Date

D. Upon receipt of medication orders, the school nurse and physician shall consult as needed.

Please Note: Only a licensed school nurse may administer *nonemergency* medication injection at school under the following conditions:

- A current physician's recommendation must be on file.
- The medication and equipment for administration must be furnished by the parent or physician.
- School district personnel and prescribing physician may communicate to clarify matters related to this medication in school.
- Changes in prescribed dose and other details of medication administration in school must be received in writing.

Physician's Signature	License No.	Telephone	Month/Day/Year
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Print Name (Physician)

I agree with the above:

Parent/Guardian's Signature	Telephone	Month/Day/Year
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TO BE COMPLETED BY PARENT OR GUARDIAN

1. Please have an **adult** deliver the medication and completed form to the school.
2. After the date for discontinuance of medication specified by the physician, changes to or continuance of these arrangements must be secured by filling out a newly dated copy of this form. All medication requests must be renewed each school year if continuation of the medication is necessary.
3. I request that the school nurse, or other person designated by the principal, administer the medication as directed by the physician on the front of this sheet. I understand that school staff has my permission to communicate with the prescribing physician on matters related to this medication.

Parent or Guardian's Signature

Month

Day

Year

PARA LLENARSE POR EL PADRE, MADRE O TUTOR

1. Por favor, pida a un **adulto** que entregue el medicamento y el formulario completo a la escuela.
2. Después de la fecha especificada por el médico para discontinuar el medicamento, se deberán indicar los cambios o la continuación del procedimiento presentando una nueva copia fechada de este formulario. Todas las solicitudes de administración de medicamentos deberán renovarse cada año escolar si es necesario continuarlos.
3. Solicito que la enfermera de la escuela, u otra persona designada por el director/directora, administre el medicamento según lo indica el médico en el frente de esta hoja. Entiendo que los empleados de la escuela tiene mi autorización para comunicarse con el médico que recetó el medicamento respecto a asuntos relacionados con este medicamento.

Firma del Padre/Madre o Tutor

Mes

Día

Año