School Year: _____

Please complete and return to the Health Clerk at school site

FREMONT UNION HIGH SCHOOL DISTRICT
PERMISSION AND INSTRUCTIONS TO TAKE MEDICATION
During School Hours

Dear Parent/Guardian:
Before medication can be taken during school hours, it is necessary to have specific written orders from your physician and written authorization from you. The school MUST be notified of any alterations to the prescription that is taken at school. In addition, we ask that you notify us of any changes in the medication taken at home that might affect your child's behavior at school. **Medication must be in Original Pharmacy Labeled container with the student's name clearly visible**. Permission must be renewed each school year. Over-the-counter medication will be given only if prescribed by a physician or dentist and in the original container. (California Education Code Section 49423)

Name of Student: _____ Address: _____

Birth date: _____ School: _____ Program (if applicable): _____

To be completed by Physician

The above named student is currently under my care and receiving medication(s) for the following condition(s):
(It is necessary for the student to take this medication during school hours.)

_____

MEDICATION TO BE TAKEN AT SCHOOL DURING SCHOOL HOURS:

1. **MEDICATION**: _____ **TIME**: _____

DOSE (Total dose-please give in mg. or ml.) _____ **ROUTE**: _____

OBSERVABLE ADVERSE REACTIONS THAT MIGHT BE SEEN AT SCHOOL:

_____

MEDICATION WILL CONTINUE FOR: ☐ DAYS ☐ MONTHS ☐ UNTIL: _____

2. **MEDICATION**: _____ **TIME:** _____

DOSE (Total dose-please give in mg. or ml.) _____ **ROUTE:** _____

OBSERVABLE ADVERSE REACTIONS THAT MIGHT BE SEEN AT SCHOOL:

_____

MEDICATION WILL CONTINUE FOR: ☐ DAYS ☐ MONTHS ☐ UNTIL: _____

The school reserves the right to contact the doctor regarding clarification if you are not available.

NOTE TO PARENT: It is your responsibility to provide the required medication(s) in original and individually prescription labeled container(s). Renewal is required for prescription changes and at the beginning of each school year.
AUTHORIZING SIGNATURES: PERMISSION TO **ADMINISTER** THE ABOVE MEDICATION(S) IS HEREBY GIVEN TO THE INSTRUCTIONAL/SCHOOL STAFF AT: _____

Physician Signature: _____ Phone: _____ Date: _____

Physician Name (Please print): _____ Phone: _____ Date: _____

Parent/Guardian Signature: _____ Day Phone: _____ Date: _____

Students attending Santa Clara County Programs: Please see Site School Nurse for Specific Instructions.