TRACY
UNIFIED SCHOOL DISTRICT

DEPARTMENT OF HEALTH SERVICES
1975 W. Lowell Ave.
Tracy, CA 95376-2238
(209) 830-3241 (209) 830-3242 fax

"The future belongs to the educated"

PERMISSION FOR MEDICATION(S) IN SCHOOL

Student's Name _____ Date of Birth _____

School _____ Grade _____ Allergies _____

Medication may be dispensed to students at school if complete information is provided and the parent/guardian agrees to the following terms and conditions. *Note: This form is valid for one school year. ED Code 49423.*

TO BE COMPLETED BY PHYSICIAN:

Medical Condition: _____

Prescribed medication: _____ Dosage: _____Route_____

Directions: _____
_____

Options for administration while at school. (Please check one:)

- ❒ Unsupervised, self administration
- ❒ Supervised, self administration
- ❒ Supervised, administration by nurse or authorized personnel

Any change in medication, dosage, or time can be authorized on your prescription blank and mailed or faxed to the school. The current authorization will be effective for one school year.

Physician's Signature _____ Date _____

Address _____ Phone number _____

TO BE COMPLETED BY PARENT/GUARDIAN:

The medication listed, prescribed and over the counter, must be taken during school hours as directed by the physician. I understand this accommodation is provided only when the schedule of medication would otherwise require the pupil to remain home, when medication is needed for emergency situations, or for specific health reasons. As the parent, I have the right to come to school and administer medication to my child if I feel it is necessary. I grant permission for the School District to exchange information with my child's doctor as deemed necessary.

I agree that said medication will be furnished to the school in a prescription labeled container with my student's name, date, name of medication, dosage, time(s) to be given, special instructions, and physician's name on it. I agree to provide appropriate dosage measuring device, especially for liquid medication.

Parent/Guardian Signature: _____ Date: _____

Address _____ _____ _____
Home phone number Work Phone number

_____ _____
School Nurse Signature Date

A:/ medications/ wd/ permission for medication/ sdh