

**PHYSICIAN INSTRUCTIONS
FOR SCHOOL ASSISTED MEDICATION**

This form must be completed before any medication (*prescription or over-the counter*) can be given, or taken, at school. **Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication. It will be automatically discontinued at the end of the school year. New orders are required each school year.**

Over the counter medications must be new, unopened with the student's name/date of birth on it.

All medications filled by a pharmacist must come with the pharmacy provided label; this includes self-carry inhalers, epi pens, etc.

Student Name: _____

Date of Birth: _____

<i>PHYSICIAN USE ONLY</i>	
1. MEDICATION: _____ Dose: _____ Reason/Diagnosis: _____	
Route: <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Topical <input type="checkbox"/> Inhale <input type="checkbox"/> Injection <input type="checkbox"/> Other _____	Stop date if a short term medication: _____
<input type="checkbox"/> If DAILY ~ Time(s) to be given: _____	
<input type="checkbox"/> If AS NEEDED (prn) ~ Frequency: <input type="checkbox"/> Every 3 to 4 hrs. <input type="checkbox"/> Every 4 to 6 hrs. <input type="checkbox"/> Other : _____	
<input type="checkbox"/> *Self carry for asthma inhaler or epinephrine auto injectors ONLY. Contract signed by parent and student.	
Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____	
<hr/>	
2. MEDICATION: _____ Dose: _____ Reason/Diagnosis: _____	
Route: <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Topical <input type="checkbox"/> Inhale <input type="checkbox"/> Injection <input type="checkbox"/> Other _____	Stop date if a short term medication: _____
<input type="checkbox"/> If DAILY ~ Time(s) to be given: _____	
<input type="checkbox"/> If AS NEEDED (prn) ~ Frequency: <input type="checkbox"/> Every 3 to 4 hrs. <input type="checkbox"/> Every 4 to 6 hrs. <input type="checkbox"/> Other : _____	
<input type="checkbox"/> *Self carry for asthma inhaler or epinephrine auto injectors ONLY. Contract signed by parent and student.	
Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____	
<hr/>	
Physician Signature: _____ Date: _____	
Physician Name: _____	
Address: _____ Phone: _____	
City: _____ Zip: _____	

California Education Code section 49423 provides that 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) a 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 matters set forth in the physician's statement.

*California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto injectable epinephrine in a manner other than as prescribed