PANAMA-BUENA VISTA UNION SCHOOL DISTRICT
Health, Safety and Wellness
4200 Ashe Rd, Bakersfield, CA 93313
Phone (661) 831-8331 ext. 6286 Fax: (661) 832-8002

PHYSICIAN'S AUTHORIZATION FOR MEDICATION TO BE TAKEN AT SCHOOL

(A separate form must be signed for each medication and is considered current for the noted school year)

Student's Name ____ Date of Birth ______________________

School __________________________________ Teacher _________________________ Grade_______________

The prescribed medication must be clearly labeled and brought to the school office in a pharmacy-labeled container. The health and well-being of the above named student is dependent upon them taking this medicine during school hours. Students will be assisted by designated/assigned, trained school personnel according to the following information:

Physical condition for which medication is to be given: ____

Name of medication:____

Method of administration (check one): □ Tablets □ Liquid □ Topical □ Other: ____________________

Dose: __________________________________ Time of Day to be Given: _______________ As Needed:__________
(Be specific, i.e., milligrams, number of puffs, etc.) *(PRN)*

If medication is to be given "as needed," describe indications: ____

This medication is to be continued as indicated above until: ____

Precautions, possible reactions and/or side effects: ____

Student may be allowed the privilege of possessing and self-administering certain life-sustaining medications when the physician believes it is necessary, the child is capable, and the medicine can be stored and taken in a safe manner (Examples: asthma inhalers, allergic reaction kits, enzymes, insulin delivery systems). **The following conditions must be met for self-administration at school:**

(MEDICAL PROVIDER'S INITIALS ARE *REQUIRED* NEXT TO THE SELECTED RESPONSE):

- *It is essential that this student carry medications at all times. Yes ______ No ______*
- *This student has been trained by the medical provider to carry and self-administer medication safely. Yes ____ No ____*

We agree to notify the school office immediately of any change in the medication, dosage, or frequency, and to sign a new statement when appreciable differences occur from the above directions. We agree to mutual sharing of information between our doctor authorized school personnel about our child's need for the medication and the expected effects or possible side effects.

____ ____

Signature: Parent or Guardian Date Signature: Physician/Licensed Health Care Provider Date

____ ____

Please Print: Parent or Guardian Please Print: Physician

____ ____

Address Address

____ ____

Home Phone Work Phone Phone Fax

Please request and complete form 709020 "Request for Special Consideration During School Hours." This form enables you to provide the additional information about your child's medical condition, early warning signs and symptoms, and list other medications taken outside of school hours.

THIS FORM IS VALID FOR THE REMAINDER OF THE SCHOOL YEAR

(See reverse side for procedures)