Office of Student Services /Special Education

Coachella Valley Unified School District

P.O. Box 847, Thermal, California 92274 Phone (760) 848-1109 Fax (760) 399-1310

AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIBED MEDICATION AT SCHOOLS WITHIN THE COUNTY OF RIVERSIDE

Name of Student	Date of Birth	Grade	School

PHYSICIAN AUTHORIZATION
ONE MEDICATION PER FORM

Name of Medicine	Health condition for which medicine RX
Time(s) to be taken	Dosage
Method of administration	Precaution – Possible untoward reactions
Date to be discontinued	Physician's Telephone Number
Name of Physician (please print)	Date
Physician's Signature	

The above mentioned student must carry this medication on his/her person. The student has demonstrated knowledge of the correct dosage and administration and is sufficiently responsible **(Middle School or older)** to carry out my directions as instructed. In addition, he/she will notify the school health office whenever he/she takes the drug for the purpose of monitoring and record keeping.

The principal or designee reserves the right to revoke the privilege if the student demonstrates irresponsible behavior or incorrect inhaler administration.

El estudiante supracitado debera traer consigo este medicamento en su persona. El estudiante ha demostrado el conocimiento apropiado de la dosis y la administracion y es suficientemente responsable (Escuela Intermediaria ó con mas edad) de llevar acabo mis instrucciones como se le instruyo. Ademas, el/ella notificara la oficina de salud en la escuela cuando el/ella toma el medicamento para el proposito de vigilar y llevar cuenta en el registro.

El director escolar ó su designado reserva el derecho de renunciar los privilegios si el estudiante demuestra ser irresponsable en su comportamiento ó el uso incorrecto de la administracion del inhalador.

We the parents of _____, desire the Coachella Valley Unified School District,
Nosotros los padres de: deseamos que el Coachella Valley Unified School District,

to comply with the orders of the above physician and will inform the school of any changes from the above. We further agree to hold the School District harmless if any injury occurs to our child due to unsupervised use of prescribed medication at school per this request.

Cumpla con las ordenes del doctor supracitado y informaremos a la escuela de cualquier cambio del supracitado. Tambien estamos de acuerdo de mantener libre de cargos al Distrito Escolar si cualquier daño ocurre a nuestro hijo(a) por el uso sin supervision en la escuela del medicamento recetado por esta solicitud.

_____ _____

Father/Guardian Padre/Tutor Date/Fech Mother/Guardian Madre/ Tutor Date/Fecha

Please return this form to your child's school health office signed by the physician and the parent or guardian. **THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR OR WHENEVER THERE IS A CHANGE IN MEDICATION OR INSTRUCTIONS.**

Por favor regrese esta forma a la oficina de salud de la escuela firmada por el doctor y el padre ó tutor. ESTA FORMA DEBE RENOVARSE AL PRINCIPIO DE CADA ANO ESCOLAR O CUANDO TENGA CAMBIOS EN EL MEDICAMENTO O LAS INSTRUCCIONES.