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

PERMISSION TO ADMINISTER MEDICATION

CONSENTIMIENTO PARA ADMINISTRAR MEDICAMIENTO

Last Name: _____ First: _____ Middle Initial: _____
Apellido Nombre Inicial

Birthdate: _____ School: _____ Date: _____
Fecha de Nacimiento Escuela Fecha

Parent/Guardian: _____ Telephone: _____
Padre/Tutor Teléfono

Address: _____
Domicilio

Physician: _____ Telephone: _____
Médico Teléfono

Medication: _____ Liquid ☐ Pill ☐ Capsule ☐ Inhaler ☐ Injection ☐
Medicamiento Líquido Pastilla Capsula Inhalador Inyeccion

Dosage: _____
Dosis

Time for administration of medication at school: _____
Hora en que se debe administrar el medicamiento en la escuela

_____

Symptoms indicating need for medication: _____
Síntomas que indican la necesidad del medicamiento

_____

Date to begin medication: _____ Date to stop medication: _____
Fecha

Possible reactions or side effects, if any, resulting from medication as expected by physician:
Reacciones posibles ó efectos secundarios, si hay algunos, que resulten de este medicamento como es esperado por el medico

_____

_____

Reactions or unusual physical; mental; or social behavior, possibly produced by medication as observed by school personnel:
Reacciones ó comportamiento fuera de lo comun; mental; ó social, posiblemente producidos por el medicamento que ha sido observado por personal escolar

_____

_____

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I have prescribed and consented that the above medication be dispensed by the Coachella Valley Unified School District authorized personnel during school hours.

Yo he rectado y consentido que el medicamento anteriomente indicado sea administrado por el personal autorizado del Distrito Unificado del Valle de Coachella.

Signature of prescribing physician (Firma del doctor) Date/Fecha

I hereby authorize the personnel of the Coachella Valley Unified School District to dispense the medication indicated above to my child during school hours. Authorized personnel shall include the school nurse or the principal or any other designated personnel.

Mediante la presente, autorizo al personal del Distrito Escolar del Valle de Coachella que administren el medicamento anteriomente indicado a mi hijo(a) durante horas escolares. El personal autorizado incluirá la enfermera, director o otra persona indicada.

☒ Parent/ Guardian signature has agreed to allow exchange of pertinent medical information between medical providers and school personnel.

☒ La firma del Padre/Tutor consta que esta de acuerdo en permitir el intercambio de informacion medica pertinente entre los proveedores medicos y el personal escolar.

☒BILL MEDI-CAL ☒MEDICATION INFORMATION ☒MEDICAL INFORMATION ☒MENTAL HEALTH INFORMATION

NOTE: ALL MEDICATIONS MUST BE IN A CONTAINER WITH PHARMACIST'S LABEL OR IN A FORM IDENTIFIED BY THE PHYSICIAN INCLUDING:

1. Child's name
2. Name of drug and dosage
3. Date prescription was filled

(In accordance with an Act to add Article 2.5 commencing with Section 12020 to Chapter 5 of Division 9 of the Education Code, relating to school)

NOTA: TODO MEDICAMENTO DEBE ESTAR EN UN ENVASE QUE CONTENGA LA ETIQUETA DE LA FARMACIA O EN UNA FORMA IDENTIFICADA POR EL MÉDICO QUE INCLUYA:

1. Nombre del niño(a)
2. Nombre de la medicina
3. Fecha en la que se surtió la receta

(De acuerdo con el Acta para agregar Articulo 2.5 comenzando con la Sección 12020 del Capitulo 5 de la División 9 del Código de Educación, relacionado con escuelas)

Signature of Parent/Guardian (Firma del Padre/Tutor) Date/Fecha