PASADENA UNIFIED SCHOOL DISTRICT
HEALTH PROGRAMS

ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Name of Student _____ Birthdate _____

Address _____ Home Phone _____

School _____ Grade _____ Teacher_____

THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER

TO THE HEALTH CARE PROVIDER: Please complete and sign the center section of this form when prescription or non-prescription medication must be given during school hours. This form is required by Section 11753.1, California Education Code, to authorize school personnel to assist the students with the administration of medication.

Date _____

Diagnosis or reason for medication:

Medication prescribed, strength, dosage, time to be taken:

Any special instruction, precautions, or possible side effects:

How long will this medication be necessary?

Signature of Health Care Provider _____ Phone _____

Printed Name of Health Care Provider _____

Address _____

THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN

TO THE PARENT OR GUARDIAN : The medication must be delivered to the school in the original pharmacy container. Middle school and senior high school students may bring their medication to the health office. The parent or guardian must bring medication for grade-school aged students.

PLEASE SIGN THE FOLLOWING STATEMENT: I request that the school assist my child, in taking the medication as directed above, and in accordance with the school policy.

Signature of parent or guardian _____ Date _____

DISTRITO ESCOLAR UNIFICADO DE PASADENA
PROGRAMAS DE SALUD

ADMINISTRACIÓN DE MEDICAMENTO DURANTE LAS HORAS DE CLASES

Nombre del Alumno _____ Fecha de Nacimiento _____

Domicilio _____ No. de Teléfono del Hogar _____

Escuela _____ Grado ____ Maestro/a _____

ESTA SECCION ES PARA QUE LA COMPLETE EL PROVEEDOR DE CUIDADO DE SALUD

TO THE HEALTH CARE PROVIDER: Please complete and sign the center section of this form when prescription or non-prescription medication must be given during school hours. This form is required by Section 11753.1, California Education Code, to authorize school personnel to assist the students with the administration of medication.

Date _____

Diagnosis or reason for medication:

Medication prescribed, strength, dosage, time to be taken:

Any special instruction, precautions, or possible side effects:

How long will this medication be necessary?

Signature of Health Care Provider _____ Phone _____

Printed Name of Health Care Provider _____

Address _____

ESTA SECCIÓN ES PARA QUE LA COMPLETE EL PADRE O TUTOR

AL PADRE O TUTOR: El medicamento debe ser entregado a la escuela en el envase original de la botica. Los estudiantes de las escuelas intermedias y secundarias pueden traer su medicamento a la oficina de salud. El padre o tutor de los alumnos de la escuela elemental deben de llevar el medicamento a la escuela.

POR FAVOR FIRMEN LA SIGUIENTE DECLARACIÓN: Pido que la escuela ayude a mi hijo/a para que se tome la medicina como es indicado arriba y de acuerdo con las reglas de la escuela.

Firma del Padre o Tutor _____ Fecha _____