Print Form

SWEETWATER
UNION HIGH SCHOOL DISTRICT

## STUDENT HEALTH SERVICES

SCHOOL SITE: _____ FAX: _____

# PHYSICIAN'S RECOMMENDATION FOR MEDICATION

This form is to be filled and signed by a licensed physician. The form should then be signed by the parents or guardians and returned to the school).*

_____ _____ _____
Pupil's Last Name First Middle

_____ _____
Age Birthdate

_____ _____ _____
Name of School Telephone/Fax Grade

The law allows any person to assist in carrying out a physician's recommendations. The school recognizes the desirability of following a physician's recommendations as nearly as possbile at school, just as does a parent at home or any other person (not necessarily a nurse) if the physician requests his assistance. The fact that this is a service or accommodation which the school is not legally required to perform is recognized by all parties signing this form, and in so signing they agree to hold the district, employees o agents, harmless from all liability, suits, claims, of whatever nature of kind, which might arise out of these arrangements.

Do you wish this child to receive medication at school? Yes ◯ No ◯

Do you wish the child to carry the medication with him/her? Yes ◯ No ◯
If yes, please fill in the following blanks:

| | Name of Medication | Form (tablet, pill, capsule, etc.) | Number to be taken | Approximate Time of Day | Observed or Assisted by Whom (self, teacher, nurse, etc.) |
|---|---|---|---|---|---|
| (1) | | | | | |
| (2) | | | | | |

Precautions if any: _____

How is medicine to be brought to school: _____

By whom (pupil, parent, etc.)? _____

How often (daily, weekly, etc.)? _____

In what kind of container (envelope, bottle, plastic container)? _____

Does the physician wish to be able to talk briefly by telephone with someone (teacher, nurse, principal, psychologist) at intervals (weekly, monthly, quarterly) to see how this chilld is faring? If so, indicate:

person(s) _____ and intervals _____ and you will be notified as to numbers and times at which the person(s) may usually be reached at school by telephone.

**IMPORTANT:** Please discontinue this request as of the following date: _____
Mo. / Day / Yr.

After this date, changes or continuance of these arrangements must be secured by filling out a newly dated copy of this form.

_____ _____ _____ _____ _____
Signature California Medical License No. Address Telephone Date

_____ _____
**Parents or guardian's full name Date

_____ _____
**Parents or guardian's full name Date

*See reverse side for legal provisions and suggestgions for school procedures.
**Signatures of both parents or guardeians are necessary if they are living with or having custody of the child.

The Sweetwater Union High School District does not discriminate with regard to sex, sexual orientation, gender, ethnic group identification, race, ancestry, national origin, religion, color, mental disability, or physical disability, age, marital or parental status or any other unlawful consideration."
SUHSD Board Policy #2224

Copy: School Nurse
Person Administering Medication

Form No. 7026- 11/07