



REGULATIONS REGARDING PUPIL MEDICATION

No pupil shall be given medication during school hours except upon written request from the parent or guardian of the pupil and a licensed physician who has the responsibility for the medical management of the pupil (Education Code Section 49423). Medication includes all pills, drops, inhalants, lotions, ointments, and injections.

School personnel, if authorized by the administrator and trained by the school nurse, may assist students who must take prescribed medication during school hours through use of the following procedures:

1. The reverse side of this page, "Request For Medication To Be Taken During School Hours," must be completed by the student's physician, signed by the parent or guardian, and filed with the school administrator. This request must be renewed each school year. If the medication program is changed, a new request form must be submitted.
2. The container must be clearly labeled with the following information:
 - a. Student's full name.
 - b. Physician's name and telephone number.
 - c. Name of medication, dosage, time schedule, adverse effects and dose form.
 - d. Date of expiration of prescription.
3. No more than a 5 day supply of any medication is to be kept at school.
4. The medication is not to be kept by the student. Special circumstances have to be evaluated on a case by case basis by the school administrator and school nurse.
5. Medication shall be kept in a secure place at all times.
6. Whenever possible, the parent or other responsible adult should come to school to administer the medication.
7. The school nurse will consider each case individually and have the authority for determining whether medication can be administered safely at school.
8. Hypodermic injections will not be given by school personnel. Any exceptions must be specifically authorized by the Coordinator of Health Services.
9. For emergency medication, such as an asthma inhaler, that needs to be carried by the student, please ask for form #HS 25c in your school health office.



REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS
 (to be completed by a licensed physician)

Last Name of Student, First Name	Sex	Date of Birth	School
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Name of Medication	Dosage	Dose Form <i>(Tablet, Liquid, etc.)</i>	Time Schedule
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Purpose of Medication	Date of Prescription	Length of Time Medication Will be Necessary
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Precautions, Special Instructions, Possible Adverse Effects, Comments: _____

Name of Physician (Please Print)	Signature of Physician	Date
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Address	Telephone	Fax Number
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PARENT REQUEST

My child's attendance at school is dependent upon his/her receiving medication during school hours. It is impossible for me to come to school to administer this medication. I hereby request that a member of the school staff designated by the principal assist in administering the prescribed medication to my child.

Student's Name _____

Prescribing Doctor _____

Name of Medication _____

Signature of Parent _____ Date _____

TO BE COMPLETED BY THE SCHOOL PRINCIPAL

Person designated to administer the medication _____

Location for locked storage of medication _____
 (5day supply only- see back page for regulations)

Plan approved: Principal's Signature _____ Date _____

Plan approved: School Nurse's Signature _____ Date _____