SANTA MONICA – MALIBU UNIFIED SCHOOL DISTRICT Department of Health Services

Medication at School Form

This form must be renewed at the beginning of each school year and whenever there is a change in the medication order.

Student Name	:	First		Date of Birth:		
	Last	First	МІ			
School:	Student		Student ID #:		Grade:	
TO B		ETED BY AN AUTI		ORNIA HEALTH C	ARE PROVIDER	
Diagnosis or Reason f	or Medicat	ion during the scho	ol day:			
Name of Medication	Meth	hod of Administration	Dosage	Time(s) to be given	Frequency & Symptoms for "as needed"	
	_					-
Precautions, reactions	, or side ef	fects:				-
Medication to be adminurse)	nistered by	r: Design	ated Unlicensed	School Personnel (i	ndirect supervision by a lic	ensed
In my professional opinephrine or Insulin/			/ May Not	carry (ONLY) asthm	a inhalers, auto-injectable	
Authorized Health Care Provider Signature				Date		
Health Care Provider Nam	e/Address (p	orint)		Phone Number		

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I request that the school staff assist my child with medication as ordered by the health care provider. I give permission for the school nurse to communicate with the health care provider on matters related to these medications.

Note: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, health care provider's name, medication, dose, method of administration, and time to administer (over-the-counter medications must be in the original containers). The medication must be delivered to the school by the parent, guardian or adult designee.

I understand that my child may only take the medications at school (including over-the-counter) if the school has received ALL of the following: 1) Current California authorized health care provider order, 2) Parent/guardian signature, and 3) Properly labeled medications.

I authorize a designated member of the school staff to assist my student with medication as ordered by the health care provider. In the case of a field trip, I authorize parent volunteers/camp staff to assist my child with medication, as above:

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date

Phone Number