Saratoga Union School District
20460 Forrest Hills Drive, Saratoga, CA. 95070
(408) 867-3424 (phone) • (408) 867-2312 (fax) • www.saratogausd.org

Request for Medication

Any pupil who is required to take, during the regular school day, prescription or non-prescription medication, may be assisted by the school nurse or other designated trained school personnel. A written statement shall be provided at least annually, and more frequently if there is a change in the pupil's health care provider, or if the medication, dosage, frequency or method of or reason for administration changes.

In order for a pupil to be assisted by a school nurse or other designated school personnel, the pupil must provide ALL of the following:

- A written statement from the physician or surgeon detailing the name of the medication, method, amount and time schedules by which the medication is to be taken.
- A written statement from the parent of the pupil indicating the desire that the District assist the pupil as indicated in the physician's written statement.
- Medications **must** be in the original container and labeled with the name of the student, the name of the prescribing physician, the name of the medication, and instructions for use.
- The prescription and the written statement **must** be current.
- Any change in prescription (dosage, intervals of administering, etc.) must be accompanied by written instructions from the physician and be reflected on a new prescription bottle label.
- All materials or equipment necessary to administer the medication **must** be provided and kept in good working order by the parent.

The District has the right to refuse to administer medication any time the above conditions are not met.

To be completed by Parent/Foster Parent/Guardian

I give my consent for exchange of information between the healthcare provider listed below, the pharmacist dispensing the medication and the Saratoga Union School District. I give my permission for the school nurse or designated school personnel to administer or assist in administering medication, as directed below, to my child.

Student Name: ________________________________

Parent/Foster Parent/Guardian signature: __________________________________ Date: ____________

To be completed by Physician

Date of prescription: __________________ Dates to be administered at school: __________________

Name of medication: ___________________ Method of administration: _________________________

Dosage to be administered: ______________ Time to be administered: __________________________
(If to be administered on an as needed basis, please explain how and when medication is to be given)

Physician signature: _______________________ Name (please print): ________________________________

Phone number: ( ) ______________________ Address: _______________________________________

It is the parents' responsibility to update this form as needed. Unused, discontinued or outdated medication will be returned to the parent when possible or disposed of at the end of the school year.

Reference: Ed Code 49423, 49414.5, 49480.5, CA Code of Reg. 600-611

Revised 05/06