EASTSIDE UNION SCHOOL DISTRICT

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS
(TO BE COMPLETED BY A LICENSED PHYSICIAN)

NAME OF PUPIL (LAST NAME, FIRST NAME, MIDDLE INITIAL)	SEX	DATE OF BIRTH	SCHOOL

NAME OF MEDICATION	PURPOSE OF MEDICATION

DOSAGE PRESCRIBED (IN MILLIGRAMS)	TIME SCHEDULE	DOSE FORM (TABLET/LIQUID/ETC)

DATE OF PRESCRIPTION	LENGTH OF TIME THIS MEDICATION WILL BE NECESSARY (Prescription expiration date) **ALL MEDICATION ORDERS EXPIRE THE LAST DAY OF CURRENT SCHOOL YEAR.**

PRECAUTIONS, SPECIAL INSTRUCTIONS, POSSIBLE ADVERSE EFFECTS, COMMENTS, ETC.

The above named pupil, for whom this medications is prescribed, is under my care:

PRINT OR TYPE NAME OF PHYSICIAN	SIGNATURE OF PHYSICIAN	
ADDRESS OF PHYSICIAN	TELEPHONE NUMBER	DATE

I request that my child (the above named pupil) be assisted in taking the above prescribed medication at school by authorized persons, and will comply with the policies and procedures of the school. I give my consent for the school nurse to communicate with the supervising physician, and to counsel with school personnel regarding the possible effects of the medication.

SIGNATURE OF PARENT OR GUARDIAN	TELEPHONE NUMBER	DATE