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. TODA LA MEDICINA ORDENADA EXPIRA EL ULTIMO DIA DEL CORIENTE AÑO ESCOLAR.		
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

Yo solicito que mi hijo(a) (el alumno nombrado arriba) sea asistido en tomar el medicamento recetado en la escuela por personas autorizadas y cumplir con las polizas y procedimientos de la escuela. Yo doy mi consentimiento a la enfermera de la escuela para que se comunique con el doctor supervisando y que consulte con el personal de la escuela en lo que concierne los posibles efectos de este medicamento.

SIGNATURE OF PARENT OR GUARDIAN	TELEPHONE NUMBER	DATE