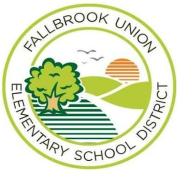

HEALTH CARE PROVIDER STATEMENT
For Medication During the School Day

Student Name: *Nombre:* ______________________ Date of birth: *Fecha de nac.:* ______________________ Grade: *Grado:* ________

School: *Escuela:* Phone #: *Tel #:* Fax #:

TO BE COMPLETED BY THE PARENT/GUARDIAN - *PARA SER COMPLETADO POR EL PADRE / TUTOR*

I authorize the school nurse, or other school staff assigned by the site principal, to administer the medication/health service as directed by the authorized health care provider. Designated school staff have my permission to communicate with the prescribing physician/health care provider on matters related to this medication/health service and condition. If my child is authorized to provide self-care, I will verify that my child is able to do so safely.
Solicito que la enfermera de la escuela, u otro empleado designado por el director/a, administre el medicamento según lo indica el médico. Entiendo que empleados designados de la escuela tienen mi autorización para comunicarse con el médico que recetó el medicamento respecto a asuntos relacionados con este medicamento.

Parent/Guardian Signature: ***Firma de Padre/Tutor:*** ______________________ **Date:** ***Fecha:*** ______________________

Parent/Guardian Name: ***Nombre de Padre/Tutor:*** ______________________ **Tel.:** ______________________

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER (California licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants - California Code of Regulations, Title 5, section 601[a]). Medication and health services may be offered at school by a licensed nurse or non-licensed, trained designee (Ed. Code 49423, 49423.1; 4 CCR602). Health care providers should contact the school nurse if the prescribed services cannot be safely administered by a non-licensed, trained designee.

Nature of condition requiring medication during the regular school day:

____

	Name of Medication	Route	Dosage	Time to be Given
1.				
2.				
3.				

Side Effects: ____

Seek Immediate Medical Assistance for (symptoms): ____

Student May Self-Carry and Administer (Medication Name): ____

Medication will be discontinued at the end of the school year or ESY (summer school) unless otherwise noted.

Physician's Name: ____ Address / Telephone Number:

Signature: ______________________ Date: ______________________