All medication orders are automatically discontinued at the end of the school year. Medication consents are renewed at the start of each school year. Please have your physician complete their portion of the consent and the parent/guardian complete their portion for all medications to be taken at school. Thank you.

WALNUT VALLEY UNIFIED SCHOOL DISTRICT
880 SO. LEMON AVE, WALNUT, CA. 91789

MEDICATION REQUIRED DURING SCHOOL HOURS

California Education Code Section 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. **Medication must be in the container in which it was purchased, with the pharmacy label attached**, and must be prescribed to the student to whom it will be administered. No medications, including over-the-counter medicine, will be given without current Physician/Podiatrist/Dentist authorization. This service is provided to enable the student to remain in school to maintain or improve the potential for education and learning.

STUDENT'S NAME: (print) _____ D.O.B. _____/_____/_____

SCHOOL OF ATTENDANCE: _____Grade _____ School Year _____

Completed by Physician/Podiatrist/Dentist; Licensed State of California Medical Care Provider

It is necessary this medication be taken during the school day.

Date patient examined _____ Reason/ Diagnosis _____

Medication Prescribed _____ Dose (puffs/mg/ml/tabs) _____

☐ **May self-carry**. *In my professional opinion, student demonstrates competence in the use of this medication.*

Route: ☐ Oral ☐ Nasal ☐ Topical ☐ Inhaled ☐ Injection ☐ Other: Med Start Date:_____ Stop Date: _____

☐ Medication to be given **DAILY**. Time(s) to be given: _____

☐ Medication to be given **AS NEEDED** (PRN). Frequency: _____

Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): _____

_____

Physician's Signature _____ Phone _____

Physician's Name (PRINT) _____ FAX # _____

Date _____

Physician's Office Stamp (REQUIRED)

Completed by Parent/Legal Guardian

I authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider regarding any questions that may arise with regard to the medication, and release the school district and school personnel from civil liability if the pupil suffers an adverse reaction as a result of self-administering medication. (CEC 49423). *In agreement with my child's physician, I request my child* ☐ ***MAY*** *or* ***MAY NOT*** ☐ *carry and use this medication him/herself.*

Parent/Guardian Signature _____ Date _____

Home Address _____

Telephone (home) _____ (work) _____

District Nurse _____ Date _____