

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: \_\_\_\_\_

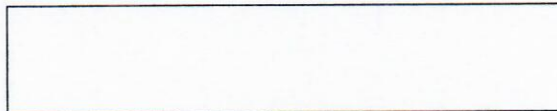
Other instructions if needed (e.g., signs/symptoms for usage, special storage, adverse reactions): \_\_\_\_\_

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 \_\_\_\_\_