ALHAMBRA
UNIFIED SCHOOL DISTRICT
HEALTH AND NURSING SERVICES

PHYSICIAN'S RECOMMENDATIONS FOR MEDICATION

This request must be filled and signed by a licensed physician, and then signed by parent or guardian and returned to the school nurse.

School: _____ Student ID #_____ Date: _____

_____ Birthdate: _____
Pupil's Last Name First Middle

It is the policy of the Alhambra School District to allow medication to be given to students at school only if attendance at school is dependent upon the medication. Education code 49423 allows this to be done if it carries out the recommendations of a qualified California licensed Health Care Professional. The district recognizes the desirability of following a physician's recommendations whenever possible.

If it is necessary for the above named student to receive medication at school, please fill in the following information:

Name of Medication	Form (pill, capsule, etc.)	Dosage	Time to be given
1._____	_____	_____	_____
2._____	_____	_____	_____

Diagnosis _____

Precautions/side effects, if any _____

IMPORTANT: THIS ORDER IS VALID TO END OF THIS SCHOOL YEAR. A new order is required each school year.

X _____
Physician Signature License No. Date

_____
Print Physician's Name Address Telephone#

I/we the parent(s) of _____ desire _____ to comply with the
Student's name School

orders of the above physician and request that the school assist our son/daughter with medication administration. I/we authorize communication between school health services and the physician regarding all questions and concerns related to the student's medication and condition for medication. I/we agree to obtain new doctor's orders whenever the medication is changed in dose, frequency, etc.

X _____ _____
Parent or Guardian's Signature Date