POMONA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES & PROGRAMS

Medication or Special Procedure Sign Off

Student_________________________________ **Grade**_____________________________

School __________________________________ **Teacher**____________________________

Check one:

____ Medication during school hours

____ Specialized health procedure during school hours

Physician's written order received on ____
Date

Parent permission request for assistance received on _______________________________________
Date

	MEDICATION	DOSAGE	TIME
1.	_______________________	_________________________	_________________________
2.	_______________________	_________________________	_________________________

SPECIAL HEALTH PROCEDURE: ____

____

____

TIME SCHEDULE: ____

____

Indications/Precautions: ____

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The following district personnel* acknowledge receiving instruction from the school nurse in providing the above service to this student. The school nurse will provide ongoing monitoring and supervision as determined by Section 3001 (T) of the California Code of Regulations, Title 5, and Education.

	Print Name	Signature	Initials	Instruction/Monitoring
1.	__________________________	______________________	______	_________________
3.	__________________________	______________________	______	_________________
4.	__________________________	______________________	______	_________________
5.	__________________________	______________________	______	_________________

*Suggested individuals include health assistant, principal, office manager, clerk-typist, teacher
*Once this form is completed place in front of medication book.

SECTION 4