ARCOHE UNION SCHOOL DISTRICT
11755 Ivie Road, P.O. Box 93
Herald, CA 95638
209-748-2313
FAX 209-748-5798

Arcohe Union School District
Educational Health Services

PERMISSION FOR MEDICATION ADMINISTRATION AT SCHOOL

_____ _____
STUDENT'S NAME BIRTHDATE

_____ Arcohe Elementary School
ADDRESS SCHOOL

We have been asked to give medication at school to the above child. If it is possible, please adjust timing of the administration to fall outside school hours as having medications in the school always presents a potential hazard to the other children. If, in your opinion, it is essential that this medication be given during school hours in order to maintain an appropriate effect upon the child, may we have this order in writing on this form?

Thank you for your cooperation.

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN

MEDICATION TO BE ADMINISTERED_____

REASON FOR MEDICATION_____

DOSAGE, MODE AND TIME OF ADMINISTRATION_____

LENGTH TO BE GIVEN WITHOUT A SUBSEQUENT ORDER_____

SIDE EFFECTS OF MEDICATION_____

WHAT OBSERVABLE EFFECTS DO YOU WISH US TO REPORT TO YOU?_____

WILL THE STUDENT NEED TO CARRY THIS MEDICATION ON HIS/HER PERSON _____YES or _____NO

PHYSICIAN'S SIGNATURE_____DATE_____

PHYSICIAN'S NAME_____PHONE_____
(Please type or print)

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

PARENT PERMISSION:

I request Arcohe Union School District personnel to administer the above medication to

_____
(Student's Name)

Reasonable care will be exercised in the administration of medications.

MEDICATION WILL BE SUPPLIED TO THE SCHOOL IN THE ORGINAL CONTAINER.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE