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

____
ADDRESS

Arcohe Elementary School
SCHOOL

We have been asked to give medication at school to the above child. <u>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.</u> 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.

<u>MEDICATION WILL BE SUPPLIED TO THE SCHOOL IN THE ORGINAL CONTAINER.</u>

____
PARENT/GUARDIAN SIGNATURE

____
DATE