Chino Valley Unified School District

5130 Riverside Drive, Chino, CA 91710-4130
(909) 628-1201 Health Ayala Fax: (909) 548-6005

PARENT and PHYSICIAN/ HCP REQUEST for the ADMINISTRATION of MEDICATION rev 5-16

Student _____ Birthdate _____ Grade ___

Address _____ Home Telephone _____

School Ayala High School _____ SCHOOL FAX: (909) _____ Attn: Health Office

PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION

The law allows any person to assist in carrying out a physician's/HCP recommendation. The school recognizes the desirability of following a physician's/HCP recommendations as nearly as possible at school, just as does a parent at home or any other person (not necessarily a nurse) if the physician/HCP requests assistance. The fact that this is a service or accommodation is recognized by all parties signing this form, and in so signing, agree to hold the District, its officers, employees, or agents harmless from all liability, suits, or claims of whatever nature or kind that might arise out of these arrangements. **I hereby authorize an exchange of information between the school nurse and the physician/HCP listed below regarding the prescribed medication(s). At school/school functions, I request that medication(s) be administered to my child by school staff or field trip/camp staff in accordance with the physician's/HCP written instructions below.**

Parent/Guardian signature _____ **Date** _____

PHYSICIAN/ HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

1)Medication_____ Diagnosis/Reason for medication_____

May Substitute Generic: ___Yes ___No Discontinue Medication at end of school year July 31,____ or_____

Dose/How administered_____ Time/Frequency/ Repeat in how many hours_____

Notify physician/HCP for the following side effects:_____

Disposition of pupil following administration of medication:_____

2)Medication_____ Diagnosis/Reason for medication_____

May Substitute Generic: ___Yes ___No Discontinue Medication at end of school year July 31,____ or_____

Dose/How administered_____ Time/Frequency/ Repeat in how many hours_____

Notify physician/HCP for the following side effects:_____

Disposition of pupil following administration of medication:_____

This student is trained to use asthma inhaler/emergency Epinephrine and student may self-administer on campus:
___yes___no Parent Signature_____ ___yes ___no Physician/HCP Signature_____

The above medication(s) may be administered by non-licensed school personnel whenever necessary.

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Physician's/HCP name (printed)_____

PHYSICIAN/HCP SIGNATURE_____

Date_____

Address_____

Telephone_____

Fax_____

Physician/HCP Office Stamp

FOR SCHOOL USE ONLY:

Date	Medication/Supplies EXP DATE	Amount Rec'd (count together)	*Signature of Parent/Guardian	Signature of Receiver

Medication procedures, parent authorization, and physician's/HCP order(s) for medication(s) have been verified by the School Nurse or Principal. *If not brought in by parent, verify receipt and amount with parent by telephone.