Chino Valley Unified School District

5130 Riverside Dr., Chino, CA 91710-4130
Phone: (909) 628-1201 Ext. 8918 Fax: (909) 548-6090

Parent and Physician/HCP Request for the Administration of Medication

Student: _____ DOB: _____ Grade: _____

Address: _____ Home Telephone: _____

School Site: _____ 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 _____ Concentration_____ Dx/Reason for Medication _____

May Substitute Generic ☐ Yes ☐ No Discontinue Medication at end of school year July 31, ____ or on _____

Dose _____ Route _____ Time of day for daily meds _____ **or**

As needed every _____ for symptoms of _____ May repeat in _____

Notify physician/HCP for the following side effects: _____

Disposition of pupil following administration of medication: _____

2. Medication _____ Concentration_____ Dx/Reason for Medication _____

May Substitute Generic ☐ Yes ☐ No Discontinue Medication at end of school year July 31, ____ or on _____

Dose _____ Route _____ Time of day for daily meds _____ **or**

As needed every _____ for symptoms of _____ May repeat in _____

Notify physician/HCP for the following side effects: _____

Disposition of pupil following administration of medication: _____

The 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** _____

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