MANHATTAN BEACH UNIFIED SCHOOL DISTRICT

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

TO BE COMPLETED BY PARENT:

Student's Last Name	First Name	Date of birth	School and Grade Level

PARENT STATEMENT:

☐ I hereby request that a school employee administer or assist in and supervise the self-administration of the medication(s) named below according to the physician's order.

I agree to provide:

- The medication(s) named below and replacement medication(s) as necessary;
- Container(s) labeled by the pharmacy and a change of label if dosage is changed;
- A new authorization for new medication(s) or changes in the dosage of the medications below.

☐ My child may carry and administer an inhaler without adult supervision. I understand and accept that no direct monitoring will be conducted by the school staff. I understand that it is the parents' responsibility to immediately notify the school if the child's health status changes, or when a change in physician and/or medication occurs. The Manhattan Beach Unified School District is not responsible for any risk involved with the improper handling of this medication including: overuse, improper administration, breakage, theft, loss, sharing, playing with, or careless storage of the medication.

I give my consent for the district nurse to communicate with the physician and to counsel with school personnel regarding the possible effects of the medication.

(Printed) Parent Name	Parent Signature	Date

Home Phone _____ Work Phone ( ) _____ Cell/Pager ( ) _____

PHYSICIAN STATEMENT:

The pupil for whom the following medication(s) is/are prescribed is under my care.

Name and form of medication	Diagnosis/Purpose of medication	Dosage prescribed	Dosage Schedule	(Circle one)	Duration of treatment
				Daily or prn	
				Daily or prn	
				Daily or prn	

Precautions, special instructions, possible adverse effects, comments: _____

☐ A school employee will administer or assist in and supervise the self-administration of the medication.

☐ This student may carry an inhaler and administer dosages without adult supervision. (Middle School and High School Students only)

Physician Signature	Date

Office Address/Phone Stamp Required 11/04