

**WILLIAM S. HART UNION HIGH SCHOOL DISTRICT**

21515 Centre Pointe Parkway, Santa Clarita, CA 91350-2948 Phone 661 259-0033 Fax 661 254-8653

**REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS**

To the Physician: Please complete and sign this form if medication prescribed for a school-age child must be given during school hours to prevent serious physical or behavioral problems. Prescribed medication includes over-the-counter medication. It is a request and guide to authorized school personnel to assist the student with medication.

School \_\_\_\_\_ School Phone Number \_\_\_\_\_ Health Office Extension \_\_\_\_\_ School Fax Number \_\_\_\_\_

Last Name of Pupil \_\_\_\_\_ First Name \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PHYSICIAN / SURGEON TO COMPLETE THE FOLLOWING:**

Purpose of Medication or Diagnosis \_\_\_\_\_ Name of Medication \_\_\_\_\_

Prescribed Dosage \_\_\_\_\_ Time Schedule \_\_\_\_\_ Dose Form (tablet or liquid) \_\_\_\_\_

Date of Prescription \_\_\_\_\_ Length of Time this Medication will be necessary \_\_\_\_\_

PRECAUTIONS, SPECIAL RECOMMENDATIONS OR INSTRUCTIONS:

POSSIBLE SIDE EFFECTS:  Sleepiness  Dizziness  Stumbling  Irritability  Nausea  
 Staggering  Vomiting  Thirstiness  Frequent Urination

The student for whom this medication is prescribed is under my care.

**PRINT** Name of Licensed Physician / Surgeon \_\_\_\_\_ **SIGNATURE** of Licensed Physician / Surgeon \_\_\_\_\_ **DATE** \_\_\_\_\_

Physician's / Surgeon's Address \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

NOTE: Medication given at home may also modify learning behavior. Therefore, we request information regarding any physician-prescribed medication given at home.

The medication listed below is prescribed for this child to be taken only before 8:00 a.m. or after 3:00 p.m.

Medication: \_\_\_\_\_ Purpose: \_\_\_\_\_  
Beginning Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

**PARENT / GUARDIAN TO COMPLETE THE FOLLOWING:**

I request that my student, \_\_\_\_\_, be assisted in taking the above prescribed medication at school by authorized persons. I will comply with the school's policies and procedures. I agree to, and do hereby hold the District and its employees harmless from any and all claims, demands, causes of action, liability or loss of any sort because of, or arising out of the acts or omissions of the District or its employee's with respect to this medication. In signing this document I specifically acknowledge that I am aware that assistance in receipt of prescribed medication may be given by the school nurse, the health assistant, or other designated school personnel.

**Emergency medical services may be called when a licensed nurse is not on site and medication is required to be administered by such a person.**

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_