

# WISE SCHOOL

## PARENT-PHYSICIAN RECOMMENDATIONS FOR MEDICATION

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

In accordance with Section 49423, of the Education Code, the school nurse or other school personnel, may assist any student who is required to take medication prescribed for him/her by a physician, during the regular school day. The fact that this is a service accommodation which the School is not legally required to perform is recognized by all parties signing this form and in so signing, they agree to hold the School or its personnel free from any or all suits which might arise out of these arrangements. Both parents and physicians signatures are required.

Name of Medication	Form (capsule, pill, etc.)	Amount to be taken	Time of Day
#1 _____			
#2 _____			

Further Instruction \_\_\_\_\_  
\_\_\_\_\_

Precautions, if any \_\_\_\_\_  
\_\_\_\_\_

## SELF-ADMINISTRATION OF PRESCRIBED MEDICATION

The above named student is under my care. His/her condition warrants immediate use of the medication listed below, and it is required that this medication be carried on his/her person. This student has demonstrated knowledge of correct dosage, usage and precautions.

Medication: \_\_\_\_\_ Form of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time/Frequency: \_\_\_\_\_

Medication Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Stop Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
State License Number

\_\_\_\_\_  
Date

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_