

**SANGER UNIFIED SCHOOL DISTRICT  
MEDICATION AT SCHOOL**

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|--------------|---------------|-------|
| Child's Name | Date of Birth | Grade |
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|               |            |            |
|---------------|------------|------------|
| Parent's Name | Home Phone | Work Phone |
|---------------|------------|------------|

Dear Parent:

Education Code Section 49423 defines certain requirements for administration of medication. “..Any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives a parent permission and physician authorization form completed for all medications, including those purchased over the counter. The student’s physician must provide a written statement detailing the amount of medication and the method and time schedules by which the medication is to be taken. Requests for administering required medication at school should be updated annually or more frequently if there is a change in the medication, dosage, or time schedule.

In addition, parents or guardians must provide the medication in a container labeled by a California pharmacist or, in the case of an over the counter medication, in the original container and should deliver the medication to the school personally or send it with a designated adult.

**PARENT’S REQUEST**

We, the undersigned, who are parents/ guardians of \_\_\_\_\_ request that the school nurse or designated school personnel assist the pupil in the matter set forth by the physician’s statement. In event of an untoward or subsequent reaction, it is understood that the school staff will in no way be held responsible for carrying out this request

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|------|------------------------------|
| Date | Signature of Parent/Guardian |
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**PHYSICIAN’S ORDERS**

1. Medication including dosage, hour, method of administration and time limit: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Condition for which medication is to be given (i.e., allergy, specific type of reaction, localized, generalized, mild, severe, etc.)

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\_\_\_\_\_

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|------|-----------------------|--------------|
| Date | Physician’s Signature | Phone Number |
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CHECK IF APPROPRIATE:

Student’s who need medication while at school may carry emergency medication (i.e. asthma inhaler, insulin)