Bellflower Unified School District

AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS

Valid *only* for the current school year, and a new form must be submitted at the beginning of each new school year.

Part 1: To be completed by Parent or Legal Guardian

NOTE: All medications must be prescribed, including over the counter medications. Medications must be in the original container and the label must contain the child's name, name of the medication, dosage, method of administration, time schedule, and name of Physician.

_______________________________________ M F ________ _______ ____________________ ___________________
Child's name Sex Birth date Age SS# Student ID#

_______________________________________ _____ ____ ________________
Name of School Grade Teacher Room No.

List all medications routinely taken *outside* of school hours: ____

I request that designated school personnel assist my child in taking this prescribed medication (including prescribed over-the counter medication), I agree to, and do hereby hold the District and its employees harmless for any and all claims, demands, causes of actions, liability or loss of any sort, because of or arising out of acts or omissions with respect to this medication. I understand that my child may not have nor take medication at school unless all requirements are met. I hereby give consent for school personnel to communicate with my child's physician and for physician to counsel school personnel regarding the possible effects of this medication and or medical condition. I will notify the school *immediately* if there are any changes in medications my child is taking at school.

____________ X ________________________________ (___)_______________ (____)________________ (___)_________________
Date **Signature** Parent or Legal Guardian Home Telephone Work Telephone Cell#/Pager#

Part 2: To be completed by Physician

The child above is under my care. It is necessary for him or her to receive the following prescribed medication during school hours.

Diagnosis for which the medication is prescribed ____

Name of medication (one medication per form)____

Dosage (Be specific, i.e., milligrams, etc.)____

Time of day to be given_____________________________ Frequency if "as needed"____

Method of administration **ORAL** __Liquid __Tablet __Inhaler **DROPS** ___ Eye R L ___ Nostril R L

OTHER __ Topical or ____

Precautions or side effects____

Storage and handling _____ Routine handling, medication in locked storage and administered by authorized school personnel
_____ 72-hour disaster supply only

If *Medical Necessity* for child to carry prescription for asthma, anaphylactic shock or diabetes:
___ Designated school personnel to administer ___ **Physician certifies child trained to self-administer**

Additional special instructions____

_____________ ____________________________________
Date **Signature** Physician

____
Please print name

____
Office Address

_____________________ ________________________
Office Telephone Office Fax

Stamp Physician name/address below

Form HS-

Revised 3/11

Distrito Escolar Unificado de Bellflower

AUTORIZACIÓN PARA TOMAR UN MEDICAMENTO DURANTE LAS HORAS DE ESCUELA

Este formulario tiene validez *únicamente* durante el presente año escolar; se debe llenar y presentar uno nuevo al inicio de cada año escolar.

Parte 1: El padre de familia o tutor legal debe completar esta parte.

NOTA: Todos los medicamentos deben ser prescritos por el médico, incluyendo los que se pueden comprar sin receta médica. Los medicamentos deben estar en su envase original y en la etiqueta debe figurar el nombre del niño, el nombre de la medicina, la dosis, la forma de administrar el medicamento, las horas en las que debe tomarse la medicina, y el nombre del doctor.

____ M F ________ ________ ____________________ ____________________

Nombre del niño | Sexo | Fecha de Nacimiento | Edad | # de SS | # de ID del alumno

____ _____ ____ ______________

Nombre de la escuela | Grado | Maestro | Salón #

Mencione todas las medicinas que el niño toma regularmente *fuera* de las horas de clases: ______________________________

Por medio de este documento, solicito que alguna persona designada por la escuela ayude a mi hijo a tomar el medicamento prescrito (lo cual incluye cualquier medicina que pueda comprarse sin receta médica). Yo estoy de acuerdo, y mediante este documento lo confirmo, en que el Distrito Escolar y sus empleados no tienen ninguna responsabilidad sobre cualquier reclamo, demanda, efectos o reacciones, obligaciones, o pérdida de cualquier tipo, debido a (o a raiz de) reacciones u omisiones relacionadas con este medicamento. Comprendo también que mi hijo podría no tomar este medicamento en la escuela si no se cumplen todos los requisitos. Mediante este documento, yo autorizo al personal de la escuela a comunicarse con el médico de mi hijo, y autorizo al médico a informar al personal escolar acerca de los posibles efectos de la medicina y o condicion medica. Me comprometo a notificar *inmediatamente* al personal escolar, acerca de cualquier cambio en los medicamentos que mi hijo toma en la escuela.

____________ X ______________________________ (___)______________ (____)______________ (___)______________

Fecha | **Firma** del Padre o Tutor Legal | Número de teléfono en casa - # de teléf. en el trabajo - # de teléf. celular o localizador

(El médico del niño debe completar esta parte).

Part 2: To be completed by Physician

The child above is under my care. It is necessary for him or her to receive the following prescribed medication during school hours.

Diagnosis for which the medication is prescribed ______________________________

Name of medication (one medication per form)______________________________

Dosage (Be specific, i.e., milligrams, etc.)______________________________

Time of day to be given______________________ Frequency if "as needed"______________________

Method of administration **ORAL** ____Liquid ____Tablet ____Inhaler **DROPS** _____ Eye R L _____ Nostril R L

OTHER __ Topical or ______________________________

Precautions or side effects______________________________

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_____ 72-hour disaster supply only

If *Medical Necessity* for child to carry prescription for asthma, anaphylactic shock or diabetes:

___ Designated school personnel to administer ___ **Physician certifies child trained to self-administer**

Additional special instructions______________________________.

____________ ______________________________

Date | **Signature** Physician

____

Please print name

____

Office Address

______________ ______________

Office Telephone | Office Fax

Stamp Physician name/address below

Form HS-

Revised 3/11