



Aliso Viejo Christian School

Parent Notification For the Administration of Medicine at School

Name of Student: _____

To The Parent / Guardian:

Medical treatment is the responsibility of the parent/guardian and an authorized health care provider (physician). An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter**, may be given at school when it is deemed absolutely necessary by the physician that the medication be given during school hours. **The parent / guardian is urged, with the help of your child's physician, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out a physician's written orders. Designated non-medical school personnel will be administering your child's medication. Medication will be safely stored and locked.

Emergency medicine such as EpiPens or inhalers may be carried by the student when recommended by a child's physician and parent. Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING CONDITIONS MUST BE MET:

1. A written statement signed by the licensed physician / dentist specifying the reason for the medication, the name, dosage, time, route, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent / guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. Any tablets requiring partial doses must be sent to school already cut.
7. A separate form is required for each medication.

NOTE: Please discuss the physician's instructions with your child, so that he/she is aware of the time medication is due at school.

Whenever there is a change in medication, dose, time, or route, the parent / guardian and physician must complete a new form.

**This request is valid for a maximum of one year
Excerpt from Capistrano Valley School District Request for Medication Form #H&W#002-08/06/03**

Dear friend, I pray that you may enjoy good health and that all may go well with you, even as your soul is getting along well. 3 John 1:2



Aliso Viejo Christian School

Parent / Guardian and Physician Request for Medication

Name of Student: _____ Birthdate: _____
Homeroom Teacher: _____ Grade: _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child, _____, in accordance with our physician's written instructions. I understand that designated school personnel will administer medication. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing physician and give permission to contact the physician when necessary.

Parent/Guardian Signature: _____ Date: _____
Telephone (Home): _____ Telephone (Cell): _____

Medication must be in the student's original, labeled pharmacy container. You may request two containers, one for school and one for home.

PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION

Diagnosis/Reason for Medication: _____

Medication: _____ Dose: _____ Route: _____ Time: _____

If PRN: Amount of time between doses _____ Maximum # of doses _____ per day

Possible medication reactions: _____

Instructions for emergency care _____

Physician's Signature: _____

Telephone Number: _____ Date of Request: _____

Date to Discontinue Medication: _____

SCHOOL USE:

Reviewed by: _____ Date: _____

This request is valid for a maximum of one year
Excerpt from Orange County Department of Education Request for Medication Form # H&W002-08/06/03

Dear friend, I pray that you may enjoy good health and that all may go well with you, even as your soul is getting along well. 3 John 1:2