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 is to be taken during school hours. Prescribed medication includes over-the-counter and homeopathic medications as well as vitamins. Only certain prescribed medications may be carried and/or self administered by the student. These medications include auto-injectable epinephrine, asthma inhalers, insulin, and glucagon. All other medications will be kept in the health office for the student. If prescribed and unless noted differently, physician's signature is confirming that the pupil is able to self-administer auto-injectable epinephrine, inhaled asthma medication, and/or insulin.

School | School Phone Number | Health Office Extension | School Fax Number

Last Name of Pupil | First Name | Grade | Date of Birth

PHYSICIAN / SURGEON TO COMPLETE THE FOLLOWING:

Purpose of Medication or Diagnosis | Name of Medication

Prescribed Dosage | Time Schedule | Method

Precautions, Recommendations, or Instructions

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

PRINT Name of Licensed Physician | **SIGNATURE** of Licensed Physician | **DATE**

Physician's Address | Phone Number | Fax Number

PARENT / GUARDIAN TO COMPLETE THE FOLLOWING:

I request that my child (named above) be assisted in taking the above prescribed medication by designated school personnel and/or consent to the self-administration of prescribed auto-injectable epinephrine, inhaled asthma medication, and/or insulin. 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. Furthermore, I release the school district and school personnel from civil liability if a self-administering pupil suffers an adverse reaction as a result of self-administering medication. As a legal parent or guardian, I authorize an exchange of records and information between physician and district nurse as needed to support my child's educational success. I understand that 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