Ramona Unified School District
Nursing and Wellness Program

PHYSICIAN'S RECOMMENDATIONS FOR MEDICATION

Birth Date:

Pupil's Last Name	First	Middle	Age	Month/Day/Year

Name of School	Name of Principal	Name of Teacher	Room No./Grade

The California Education Code relating to the giving of medications at school states:

> 49423, Notwithstanding the provisions of Section 49422, 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 (1.) written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2.) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.

The Ramona Unified School District has implemented this policy. The information requested on this form is necessary to comply with the law and to insure adequate protection for pupils.

TO BE COMPLETED BY A LICENSED PHYSICIAN

A. **Nature of the condition** requiring medication during the regular school day:

B. NAME OF MEDICATION / METHOD OF ADMINISTRATION / DOSAGE / APPROX. TIME OF DAY

1.
2.

C. Discontinue Medication No. 1 on ______________ (Date); discontinue Medication No. 2 on ______________ (Date)

D. Upon receipt of medication orders, the school nurse and physician shall consult as needed.

Please Note: Only a licensed school nurse may administer *nonemergency* medication injection at school under the following conditions:

- A current physician's recommendation must be on file.
- The medication and equipment for administration must be furnished by the parent or physician.
- Parent may file a written alternate procedure to be followed in the event of an *emergency* in the absence of the nurse.

E. Do you wish to talk briefly, by telephone, with the nurse or other school person at intervals to discuss effect of medication? If so, indicate approximate interval:

Physician's Signature	License No.	Telephone	Month/Day/Year

Print Name (Physician)

I agree with the above:

Parent/Guardian's Signature	Telephone	Month/Day/Year

The following must be completed by parent or guardian