San Diego Unified SCHOOL DISTRICT

Nursing and Wellness Program

PHYSICIAN'S RECOMMENDATIONS FOR MEDICATION DURING THE SCHOOL DAY

Student's Last Name _____ First Name _____ Middle Initial _____ DOB: month/day/year _____ Grade/Room# _____

Name of School _____ School Phone Number _____ School Fax Number _____ Site School Nurse (if applicable) _____

In accordance with California Education Code section. 49423, this form must be completed by a California licensed physician (or other healthcare provider who has the authority to prescribe medication) and be on file for any student who requires medication(s) during the regular school day. *De acuerdo con sección de Código de Educación de California. 49423, esta forma debe ser completada por un médico licenciado en California (u otro proveedor de salud que tiene la autoridad para prescribir medicamento) y estar en el archivo para cualquier estudiante que requiere medicinas durante el día regular de escuela.*

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER
(California licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants - California Code of Regulations, Title 5, section 601[a])

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

_____

B.

	Name of Medication	Method of Administration	Dosage Amount	Time to be given	Frequency
1.					
2.					

C. Discontinue Medication #1 (date): _____ Discontinue Medication #2 (date): _____

Health Care Provider's Name (print): _____ **Signature:** _____

License No. _____ **Phone No:** _____ **Fax No.** _____ **Date:** _____

Supervising Physician's Name/Address/Phone# (if applies): _____

D. Upon receipt of medication orders, the school nurse and the prescribing health care provider shall consult as needed.
1. A current medication form must be on file. **A new form must be on file each school year for each medication.**
2. Changes in prescribed dose and other details of medication administration must be provided to the school in writing by the authorized health care provider.
3. All medication must be in a container labeled by a pharmacist or prescribing health care provider.
4. An adult must bring the medication to the school and pick up any outdated, unused or for home use medication.
5. All medication not picked up by an adult on the last school day will be discarded, unless otherwise arranged.
6. Parents/Guardians must provide all materials or necessary equipment for medication administration.

Cuando recibimos las ordenes para medicamentos, la enfermera y el médico se consultarán cuando sea necesario.
1. *Una forma actual de medicamento debe estar en el archivo.* ***Una forma nueva se necesita cada año escolar.***
2. *Los cambios en dosis prescrita y otros detalles de administración de medicamentos debe ser proporcionada a la escuela por escrito por el médico autorizado.*
3. *Todos los medicamentos deben estar en un recipiente etiquetado con el farmacéutico o médico.*
4. *Un adulto debe traer el medicamento a la escuela y recoger medicamento vencido, que no se ha usado, o medicamento que el estudiante va a utilizar en el hogar.*
5. *Todos los medicamentos no recogidos por un adulto el último día del año escolar serán desechados, a menos que otros planes se han hecho con la escuela.*
6. *Padres/Tutores deben proporcionar todo lo que se necesita para administrar el medicamento.*

I authorize the school nurse, or other school staff assigned by the site principal, to administer the medication as directed by the authorized health care provider. I understand that designated school staff has my permission to communicate with the prescribing physician/health care provider on matters related to this medication. *Solicito que la enfermera de escuela, u otro empleado designado por el director/a, administre el medicamento según lo indica el médico. Entiendo que empleados designados de la escuela tienen mi autorización para comunicarse con el médico que recetó el medicamento respeto a asuntos relacionados con este medicamento.*

_____ _____ _____
Parent/Guardian's Signature **Daytime Phone Number** **Month/Day/Year**

_____ _____ _____
Reviewed by (Name of School Nurse) **School Nurse's Signature** **Month/Day/Year**