HARVEST CHRISTIAN SCHOOL

Administration of Prescribed Medication for Pupil

(Education Code Section 49423)

TO: ______________________________________
(Principal's Name)

1. Physician's Statement

____ is under my professional care and is on the following medication:

Medication: ____________________________________ Current Dosage: __________

Method medication is taken ____

Date medication to be started _________________ Date to be ended ______________

Time schedule ____

Precautions, if any ____

____

I recommend that the school nurse or other designated school personnel assist in the administering of the prescribed medication during school hours.

Date: ______________ Signature of Physician: ______________________________

2. Parent(s) or Guardian Statement:

As the parent(s) or guardian of ____
(Student's Name)

(we) (I) request Harvest Christian School assist in carrying out ____________________
(Physician's Name)

instructions in the administering of the prescribed medication during the school day.

Date: ____________ Signature of Parent/Guardian: ______________________________

NO MEDICATION WILL BE ADMINISTERED WITHOUT THE SIGNATURES OF THE PHYSICIAN AND PARENT/GUARDIAN

(Please return this form to the school office)

Note: When possible medication should be administered outside of the school day. The school should be requested to assist the child with medication only in exceptional cases when the child's health condition requires medication during the hours school is in session.