MIS #:_____

San Bernardino City Unified School District
Health Services

PHYSICIAN'S RECOMMENDATIONS FOR MEDICATION

Pupil's Last Name	First Name	M.I.	Age	Birthdate	School	Grade

The law allows school nurses or other designated personnel to assist the pupil in taking prescribed medications if specified written statements from physicians and parent or guardian of pupil are obtained by the district.
Ed. Code 49423.

I hereby give my permission for school personnel to give the medication(s) listed below as directed. I also give the school nurse permission to contact the physician regarding the child's reaction to the medication or if there is a change in the child's health.

Parent or Guardian Signature	Address	Telephone	Date

RECOMMENDATIONS SHOULD BE COMPLETED BY PHYSICIAN ONLY

IMPORTANT: All medications will automatically be discontinued on June 30. New orders are required each school year.

#1 _____ (Medication) _____ (Strength) _____ (Dose) _____ (Route) (Circle One) **Routine**_____ **Time(s) to be given (AT SCHOOL)**

PRN_____ **Frequency** _____ **Stop Date**

If PRN, give for:_____

Side Effects, if any:_____

_____

#2 _____ (Medication) _____ (Strength) _____ (Dose) _____ (Route) (Circle One) **Routine** _____ **Time(s) to be given (AT SCHOOL**

PRN_____ **Frequency** _____ **Stop Date**

If PRN, give for: _____

Side Effects, if any:_____

_____

#3_____ (Medication) _____ (Strength) _____ (Dose) _____ (Route) (Circle One) **Routine**_____ **Time(s) to be given (AT SCHOOL)**

PRN _____ **Frequency** _____ **Stop Date**

If PRN, give for:_____

Side Effects, if any:_____

_____

ıysician's Name (Printed)	Signature	Address	Date

HE-24 (6-98)

Telephone_____ **FAX #**_____