

TORRANCE UNIFIED SCHOOL DISTRICT

School: _____ Health Office #: _____, fax #: _____

AUTHORIZATION for MEDICATION at SCHOOL

TO BE COMPLETED BY PARENT:

Last Name of Pupil, First Name Grade Sex Date of Birth School

The above named pupil is required to take medication prescribed by a physician during the regular school day. I request that designated School District personnel assist my child in taking the medication in accordance with the instructions provided below by the physician. I authorize the District to communicate with the physician regarding my child's medical condition and/or the medication prescribed for it.

Date Telephone number(s) Signature of Parent or Guardian

TO BE COMPLETED BY A LICENSED PHYSICIAN:

Purpose of Medication Name of Medication

Dosage Prescribed Dose Form (Tablet, Liquid, etc.) Time Schedule at **SCHOOL**

Date of Prescription Length of Time This Medication Will be Necessary

Precise Method of Administering Medication: _____

DESCRIBE PRECAUTIONS, SPECIAL INSTRUCTIONS, POSSIBLE ADVERSE SIDE EFFECTS, OR OTHER COMMENTS (PLEASE INCLUDE STORAGE INSTRUCTIONS):

There may be circumstances where it is important for the student to have the medication on their person:

- Yes, student to carry his/her med/inhaler (**life sustaining medications only**) on campus. I agree that the student is capable of self-administration and is able to manage this medication responsibly.
- Yes, but keep a backup dosage/inhaler in the health office.
- No, health office is best location, student requires supervision or medication is not life sustaining.

The pupil, for whom this medication is prescribed, is under my care.

Print Name of Physician Signature of Physician

Address Telephone Date

THIS REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR IN WHICH MADE.
Please read TUSD Medication Policies on reverse side.