TORRANCE UNIFIED SCHOOL DISTRICT

School: _____ Health Office: (310) _____ Fax: (310) 972-_____

AUTHORIZATIONS 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 an authorized health care provider 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. I have read and understand TUSD policy regarding medications at school as stated on the back of this form.

_____ _____ _____

Date | Telephone Number(s) | Parent/Guardian Signature

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER:

_____ _____ _____

Name of Medication and Dose Form (tablet, liquid, drops, etc.) | Dose | Route

_____ _____

Time Scheduled at School **OR** Frequency (for as needed medications) | Duration of Treatment

Purpose of Medication: _____

DESCRIBE SPECIFIC SYMPTOMS, PRECAUTIONS, SPECIAL INSTRUCTION, POSSIBLE ADVERSE SIDE EFFECTS, OR OTHER COMMNETS (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 inhaler on campus. I agree that the student is capable of self-administration and is able to manage this medication responsibly.

☐ Yes, also keep a backup inhaler in the health office.

☐ No, health office is best location, student requires supervision.

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

_____ _____

Physician's Stamp | Signature of Physician

_____ _____ _____

Address | Telephone | Date

TO BE COMPLETED BY SCHOOL STAFF UPON RECIEPT OF MEDICATION:

- Medication received matches physician's order (name, dose form, dosage, unopened for OTC) _____
- Quantity initially received _____

_____ _____

Parent/Guardian Signature | Date | Staff Signature | Date

TO BE COMPLETED BY SCHOOL STAFF UPON PICK UP OF UNUSED MEDICATION:

- Quantity picked up _____

_____ _____

Parent/Guardian Signature | Date | Staff Signature | Date