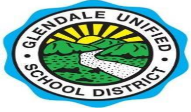

GLENDALE UNIFIED SCHOOL DISTRICT
223 North Jackson St., Glendale, California 91206-4380
Telephone: 818-241-3111, Ext. 1407 • Fax: 818-547-0213

OFFICE OF
STUDENT SUPPORT SERVICES
Health Services

Request for Medication to be Taken During School Hours

Last Name: ______________________ First Name: _____________________

School: _________________________ ID #: ___________________________

Gender: ____________ Date of Birth: ____________________

Completed by a licensed physician:

Medication #1	Dose/Route	Form (Tablet, Liquid, etc.)	Time
Purpose	Date of Prescription	Expiration Date	Length of time necessary
Medication #2	Dose/Route	Form (Tablet, Liquid, etc.)	Time
Purpose	Date of Prescription	Expiration Date	Length of time necessary

Precautions, Special Instructions, Possible Adverse Effects, Comments:

____

____

□ Student may Self –Carry Medication

________________________ ______________________ ___________

Name of Physician (Please Print) Signature of Physician Date

Physician Office Stamp

Parent Request

My child's attendance at school is dependent upon his/her receiving medication during school hours. It is impossible for me to come to school to administer this medication. I hereby request that a member of the school staff designated by the principal assist in administering the prescribed medication to my child.

____________________________ ______________________ ____________________

Parent/Guardian Name (Please Print) Signature of Parent/Guardian Date

To Be Completed by the School Nurse

Person designated to administer the medication: ____

Location of locked medication storage: ____

Plan Approved: Principal's Signature: ________________________________ Date: ________________

Plan Approved: School Nurse Signature: ______________________________ Date: ________________