BURBANK UNIFIED SCHOOL DISTRICT
DEPARTMENT OF PUPIL SERVICES
HEALTH SERVICES

REQUEST FOR ASSISTANCE WITH MEDICATION DURING REGULAR SCHOOL DAY

TO BE COMPLETED BY PARENT:

Last Name of Pupil (Nombre Ultimo)	First Name (Primero)	Sex (Sexo)	Date of Birth (Fecha de Nacimiento)	School (Escuela)

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 below regarding my child's medical condition and/or the medication prescribed for the condition.

Date (Fecha)	Telephone (Telefono)	Signature of Parent/Guardian (Firma de Padre o Guardian)
	( )	

TO BE COMPLETED BY A LICENSED PHYSICIAN:

Purpose of Medication

Name of Medication

Dosage Prescribed

Time Schedule

Dose Form (tablet, liquid, etc.)

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):

The pupil named above 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 reverse side