Assistance League® of Flintridge
SUMMER SCHOOL

PHYSICIAN'S RECOMMENDATIONS FOR MEDICATION

This request is to be filled in and signed by a licensed physician; the request should then be signed by the parent/guardian and returned to school.

Student Name_____ Date of birth: _____

School: _____ Grade:_____ Teacher:_____

Diagnosis or Indication for Medication: _____

Name of Medication	Form (capsule, tablet, etc.)	Dosage	Approximate Time of Day

PRECAUTIONS: Special Instructions, Possible Adverse Effects, Comments:

_____

_____

Effective date: from: _____ to: _____

It is necessary for this medication to be taken during the school day at the time(s) indicated above and the medication may be administered by medically untrained personnel.

Physician's Signature: _____ Date: _____

Physician Name (print): _____ License No.: _____

Address: _____ Phone: _____

The law allows any person to assist in carrying out a physician's recommendations. The school recognizes the desirability of following a physician's recommendations as nearly as possible. The fact that this is a service or accommodation which the school is not legally required to perform is recognized by all parties signing this form, and in so signing they agree to hold the school or its personnel free from any or all suits which might arise out of these arrangements.

I request that my child, _____ be assisted in taking the above prescribed medication at school by authorized persons, and will comply with the school's policies and procedures listed on the back of this form. I also give my permission for school personnel to contact the physician for further information if necessary.

Parent/Guardian Signature: _____ Date:_____

Phone: Home: _____ Work: _____

This form must be renewed whenever the prescription changes and is valid through the duration of the summer session. A new form is required each year.