MEDICATION CONTINUANCE

Name / Nombre: _____ Teacher / Maestro(a):_____

School / Escuela: _____ Grade / Grado: _____ Date / Fecha:_____

DISPENSING MEDICATION AT SCHOOL FOR LONGER THAN 10 DAYS

In order for your child to continue taking medications for more than ten days at school we will need approval from your child's physician. Please have him / her complete the information below and return this form to the nurse's office. Thank you.

ADMINISTRADO MEDICINA EN LA ESCUELA POR MAS DE 10 DIAS

Para que su niño/niña pueda seguir recibiendo medicina por más de 10 días se requiere autorización en escrito por el proveedor de salud. Favor de llevar esta forma para que el médico la complete. Favor de devolver la forma a la enfermera. Gracias.

TO BE COMPLETED BY PHYSICIAN / HEALTH CARE PROVIDER

_____is under my care for _____

Child's Name Condition / Diagnosis

And is being prescribed the following medication to be given at school.

1.) MEDICATION: _____ DOSAGE: _____TIMES: _____

SIDE EFFECTS / CONTRAINDICATIONS: _____

Is child to receive this medication at home? Yes___ No___ If parent informs the school that the child did not receive an ordered AM dose of this medication; may it be administered at school? Yes___ No___ May administer no later than AM / Dosage_____

2.) MEDICATION: _____ DOSAGE: _____TIMES:_____

SIDE EFFECTS / CONTRAINDICATIONS: _____

Is child to receive this medication at home? Yes___ No___ If parent informs the school that the child did not receive an ordered AM dose of this medication; may it be administered at school? Yes___ No___ May administer no later than AM / Dosage_____

Inhaler may be carried by the student at school: Yes___ No___

Epi-Pen may be carried by the student at school: Yes___ No__

_____ _____ _____

Signature of Doctor / Health Care Provider Phone# Date

TO BE COMPLETED BY PARENT / GUARDIAN

I hereby authorize the above medication be given to my child as stated by my child's Physician / Health Care Provider. It is also understood to be the parents responsibility to instruct the child to go to the nurse's office to receive medication. I further release the aforesaid health care provider from all legal responsibility or liability which may arise from the act which I authorized above. This release shall be valid for a period of one year from the date doctors signature.

Autorizo la administración de el/los medicamentos recetado/s por el médico proveedor de salud para mi niño/a. Es la responsabilidad de el padre / guardián que el niño/a vaya a la oficina de le enfermera por el medicamento. Yo retiro la responsabilidad del distrito escolar y departamento de enfermería de todo problema legal que se pueda presentar con esta autorización. Esta autorización será valida por el periodo de un ano a partir de la fecha de firma de el doctor.

_____ _____

Parent / Guardian signature – Firma de Padre / Guardian Date / Fecha