Palmdale School District
Launching a lifetime of learning

Health Services
39139 10th St. East
Palmdale, CA 93550
661.789.6718 Phone
661.789.6791 Fax
www.palmdalesd.org

REQUEST FOR ASSISTANCE WITH MEDICATION DURING SCHOOL HOURS 2019-20

Parents:

This form must be completed by your doctor BEFORE any medication can be given to your child at school. This includes **all** over-the-counter drugs such as aspirin, cough syrup, allergy and cold tablets, anti-histamine, throat lozenges, etc. If your child requires medication during the school hours, please bring this completed "Request for Assistance with Medication" form and the necessary medication to the school's health office. **Do not send any medication to school with your child.**

STUDENT'S LAST NAME, FIRST:	SEX:	DATE OF BIRTH:	GRADE:	SCHOOL:
HOME ADDRESS:				**PHONE:**

TO BE COMPLETED BY A CA LICENSED PHYSICIAN

Purpose of Medication:	**Name of Medication:**
Dosage:	**Time Schedule/Frequency:**
Method of Administering:	
Duration of Medication Administration:	
Precautions, special instructions, possible adverse side effects, storage instructions:	

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

PRINT OR TYPE NAME OF PHYSICIAN:	**SIGNATURE OF PHYSICIAN:** X	
ADDRESS:	**Telephone:**	**Date:**
LICENSE #:	**NPI #:**	

I authorize the above physician or designee to release information regarding my child's health condition and related medical treatment plan, assessment progress notes, and special instructions to the Health Staff of Palmdale School District for purposes of meeting my child's health needs while in school. I also authorize the PSD Health Staff to communicate with the above physician or designee regarding behavior/symptoms and health concerns at school for purposes of meeting my child's health needs while in school.

X

Signature of Parent/Guardian **Telephone # during school hours**

E-301 3-25-2019

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PETICION PARA ASISTENCIA CON MEDICAMENTOS DURANTE LAS HORAS ESCOLARES 2019-20

Padres de Familia:

Este formulario debe de ser llenado por su doctor ANTES de que cualquier medicamento pueda ser administrado en la escuela a sus hijos. Esto incluye **todo** tipo de medicinas que se venden en las tiendas, tales como la aspirina, el jarabe para la tos, las pastillas para alergias o resfriados, anti-histaminas, las pastillas para el dolor de la garganta, etc. Si su hijo(a) necesita tomar medicina en la escuela durante el día, por favor complete y entregue este formulario "Petición para Asistencia con Medicamentos" la planilla y la medicina necesaria a la oficina de salud en la escuela. **No mande ninguna medicina a la escuela con su hijo(a).**

APELLIDO, NOMBRE DEL ALUMNO:	SEXO:	FECHA DE NACIMENTO	GRADO:	ESCUELA:
DIRECCION DE RESIDENCIA:				**TELEFONO:**

TO BE COMPLETED BY A CA LICENSED PHYSICIAN

Purpose of Medication:	**Name of Medication:**
Dosage:	**Time Schedule/Frequency:**
Method of Administering:	
Duration of Medication Administration:	
Precautions, special instructions, possible adverse side effects, storage instructions:	

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

PRINT OR TYPE NAME OF PHYSICIAN:	**SIGNATURE OF PHYSICIAN :** ***X***	
ADDRESS:	**Telephone:**	**Date:**
LICENSE #:	**NPI #:**	

Yo autorizo al medico o designado a dar información en referencia a la condición de salud de mi hijo(a) y de todo plan medico relacionado al tratamiento, notas del progreso de evaluación, y las instrucciones especiales al Personal de Salud del Distrito Escolar de Palmdale, con el propósito de satisfacer las necesidades de salud de mi hijo(a) cuando se encuentra en la escuela. Yo también autorizo al personal de salud PSD para que se comunique con el doctor mencionado o designando, con respecto al comportamiento/síntomas y preocupaciones de salud, con el propósito de satisfacer las necesidades de salud de mi hijo(a) cuando se encuentra en la escuela.

*X*_____ _____

Firma de Padres de Familia/Guardián **Número de teléfono durante las horas de escuela**

E-301 3-25-2019