PHYSICIAN'S STATEMENT

This portion to be completed by school personnel.

Name of Pupil _____ Birthdate _____
Last First Middle Month Day Year

School _____ Teacher _____ Room _____ Grade _____

This form valid only for school year 20 ____ to 20 ____.

Location of medication (Building, Room Number, Cabinet) _____

Type of container _____

Person(s) authorized to assist pupil (Nurse, Secretary, Self) _____

Who is to bring medication to school? (Name of Person) _____

How often will medication be brought to school? (Daily, Weekly, etc.) _____

The "Authorization for Medication Administration" form must also be completed by parent and returned to school along with this form.

This portion to be completed by a physician licensed in the State of California.

1. Name of Medication / Method of Administration / Dosage / Approx. Time of Day

   #1 _____ _____ _____ _____

   #2 _____ _____ _____ _____

2. Diagnosis (es) _____
3. Discontinue medication #1 on (Date)_____ and medication #2 on (Date) _____
4. Type of assistance for administering medication (Observe, Measure, etc.) _____
5. Precautions for administration of medication _____
6. Asthmatic/Diabetics **ONLY**

   _____**NO** _____**YES- Supervised** _____ **YES- Unsupervised**

   This student may carry this medication: _____ **NO** _____ **YES**
7. Do you wish to have school personnel contact you at intervals to discuss this medication? ☐ YES ☐ NO

   Please indicate: Person(s) _____ Intervals _____
   Teacher, Nurse, Psychologist, etc. Daily, Weekly, Quarterly, etc.

_____M.D. _____ _____
Printed Name of Physician Telephone Number Fax Number

_____M.D. _____ _____
Signature of Physician Date Medical License Number

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