



Davis Joint Unified School District

Birch Lane (Fax)- 757-5413
Cesar Chavez (Fax) – 757-5427
Korematsu ((Fax)- 757-5362
Montgomery (Fax)- 759-2103
North Davis (Fax)- 757-5477

Patwin (Fax)- 757-5417
Pioneer (Fax)- 757-5482
Willett (Fax)- 757-5428
Emerson (Fax)- 757-5434
Harper (Fax)- 757-5350

Holmes (Fax)- 757-5435
Davis High (Fax)- 757-5492
DaVinci High (Fax)- 759-2178
King High (Fax)- 757-5440

Request for Assistance with Medication By School Personnel

Any student who is required to take prescription or over-the-counter medication prescribed by a physician may be assisted by a school nurse or other designated school personnel. This accommodation is provided only when the schedule of medication would otherwise require the student to remain home, when medication is needed for emergency situations, or for specific health reasons.

All medication administered at school must be provided to the school in the original container from the pharmacist, complete with the physician’s directions on the container detailing the method, amount, and time schedule by which the medication is to be taken. *If the dosage is changed it must indicate so in writing on the medication form and on the prescription label.* The parent/guardian must provide an appropriate dosage measuring device, especially for liquid medication.

All information requested below is necessary if school personnel are to give medication to a student during school hours:

1. Student’s Full Name _____
2. School _____
3. Medication Name _____
4. Diagnosis _____
5. Prescription Number _____ Dosage _____
6. Name of Pharmacy Filling Prescription _____ Phone _____
7. Name of Physician Prescribing Medication _____ Phone _____
8. Time(s) of Day Medication is to be Administered _____
9. Anticipated Reactions, if any, to Medication _____

My signature below verifies that:

1. I am the parent or legal guardian of the student named hereon;
2. The medication I am providing is in the original container from the pharmacist, complete with physician’s directions on the container;
3. I agree to hold the Davis Joint School District harmless from any and all liability resulting from the administration of medication in the manner directed.

Date

Signature of Parent/Legal Guardian

Date

Physician’s Signature