OAKDALE JOINT UNIFIED SCHOOL DISTRICT
OFFICE OF HEALTH SERVICES

❑ Oakdale High School
739 West "G" Street
848-7193 Fax: 848-5841

❑ Fair Oaks Elementary
151 North Lee Avenue
847-0391 Fax: 847-9067

❑ Oakdale Jr. High School
400 Maag Avenue
847-2294 Fax: 847-8521

❑ Cloverland Elementary
201 Johnson Avenue
847-4276 Fax: 847-9059

❑ Magnolia Elementary
739 Magnolia Avenue
847-5056 Fax: 848-0815

❑ Sierra View Elementary
1323 East J Street
848-4200 Fax: 848-4203

District Office 168 South 3rd Avenue (209) 848-4884 Fax: (209) 847-0155

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

STUDENT: ________________________________ BIRTH DATE: ______________

TEACHER: ________________________________ GRADE: ________________

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

NAME OF MEDICATION: ____

REASON FOR MEDICATION: ____

DOSE: ____

TIME GIVEN: ________________ METHOD OF ADMINISTRATION: ______________

Beginning: Immediately Other Date: __________
Ending: End of year Other Date/Duration: ______________

For Episodic or Emergency events only

RESTRICTIONS AND/OR POSSIBLE REACTIONS

None anticipated Yes, please describe: ______________________________

SPECIAL STORAGE REQUIREMENTS: Refrigeration None

PHYSICIAN'S SIGNATURE: __________________________ Date: ____________

Phone Number: ____________________ Physician's Office Stamp or Name/Address:

Fax: ___________________________

TO BE COMPLETED BY PARENT OR GUARDIAN
PARENT CONSENT FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

Parent(s)/Guardian(s) of ____________________, request that medicine be administered by the school nurse or a member of the school staff if the school nurse is not available. I consent to allow disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel. I will notify the school if the medication has changed or is no longer needed. Medication will be furnished in its pharmacy-labeled container. I understand that this medication will be destroyed if it is not claimed within one week following the termination of the physician's authorization or one week beyond the end of the school year.

Parent/Guardian Signature: ____________________________ Date: ____________
Daytime Phone #: ____________________ Address: ________________________

THIS REQUEST *MUST* BE UPDATED ANNUALLY (AT THE BEGINNING OF EACH NEW SCHOOL YEAR).