DISTRITO UNIFICADO ESCOLAR de MADERA
1902 HOWARD ROAD • MADERA CA 93637

SERVICIOS ESCOLARES de SALUD

AUTORIZACIÓN PARA AYUDAR A UN ALUMINO/A EN TOMAR MEDICINA
Y
AUTORIZACIÓN PARA DAR INFORMACIÓN MEDICA

Por la presente, pido a las autoridades de la escuela que ayuden a mi hijo/hija, (nombre)

(escuela) (caril) (grado)

tomar la medicina indicada abajo que yo mandaré la escuela para el tiempo necesario según la receta medica.

Fecha: ______________________ ______________________________
Firma de Padre o Guardián

Teléfono: ______________________ **Dirección:** ______________________________

TO PHYSICIAN: Under certain unusual circumstances, a pupil with a chronic health problem may require medication during school hours in order to participate in the regular program. Your recommendations will be used according to Education code Section 49423 to assist the above pupil in taking a required medication. This authorization will remain in effect for one year.

____
Signature of school nurse

Diagnosis or description of chronic health problem: ______________________________

____

____

Name, dosage, frequency, and duration of medication under prescription: ______________________

____

____

Side effects which school should be alert for and notify parent and doctor regarding:

____

____

Limitations of physical activity: ______________________________

____

____

Date: ______________________ ______________________________
Signature of physician

Telephone: ______________________ **Address:** ______________________________

May Carry Medication ____Yes ___No ______________________________

N-1020