Santa Clara Elementary School
324 South E Street
Oxnard, California 93030
(805) 483-6935
www.scesoxanrd.org

Regulations on the Administration of Medication during School Hours

General Policy:

- No pupil shall be given medications during school hours except upon the written request from a licensed physician who has the responsibility for the medical management of the pupil. All such requests must signed by the parent/guardian.

Responsibilities of the Parents/Guardians:

- Parents/guardians will assume full responsibility for the supplying of all medications.
- No medications may be brought to school by pupils.
- Parents/guardians shall deliver or cause to be delivered by an adult or an authorized employee of a pharmaceutical supplier, any medication to be administered under the provision of this policy.

Responsibility of the Physician:

- A request form for each prescribed medication must be completed by the pupil's physician, signed by the parent/guardian, and filed with the school administrator or his/her designated representative.
- The container must be clearly labeled with the following information:
    1. Pupil's full name
    2. Physician's name
    3. Physician's telephone number
    4. Name of medication
    5. Dosage, schedule and dose form
    6. Date of expiration of prescription
- Each medication is to be in a separate contained labeled as above

Responsibility of School Personnel:

- Pupils taking medication will be assisted by authorized school personnel. This shall be done in accordance with the physician's instructions.
- All medications administered by school personnel must be kept locked in a secure place.

See reverse side for Form No. PPSD-5 "Request for Medication to be taken during School Hours".

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Division of Instructions
Department of Pupil Personnel Services
Health Services

Request for Medication to be taken during School Hours

To be completed by Parent/Guardian:			
Last Name of Pupil:	**First Name of Pupil**	**Sex**	**Date of Birth:**
I request that my child, named above, be assisted in taking the prescribed medication at school by authorized persons, and will comply with the school's policies and procedures.			
Date:	**Telephone:**	**Signature Parent/Guardian**	

To be completed by a Licensed Physician:		
Purpose of Medication:	**Name of Medication(s)**	
Dosage (mg):	**Time to be Taken:**	**Dose Form (tablet, liquid, inhalant):**
Date of Rx:	**Length of time this medication to be taken at school:**	
Precautions or Special Instructions:		
Signature of Physician:		
Print Name of Physician:		
Address:	**Telephone:**	**Date:**
Medication to be sent home: ☐ **Daily** ☐ **Other:**		

PPSD-5

This request must be renewed each year – Please read reverse side