

**Saugus Union School District  
 Agreement to Assist Student with  
 Prescription and/or Non-Prescription Medication**

\_\_\_\_\_  
 Pupil's Last Name

\_\_\_\_\_  
 First Name

\_\_\_\_\_  
 School

\_\_\_\_\_  
 Sex

\_\_\_\_\_  
 Date of Birth

**(THIS SECTION TO BE COMPLETED BY A CALIFORNIA LICENSED PHYSICIAN.)**

The pupil for whom this medication is prescribed is under my care.

\_\_\_\_\_  
 Purpose of Medication/Diagnosis

\_\_\_\_\_  
 Name of Medication

\_\_\_\_\_  
 Form (Tablet, Liquid, etc)

- QD
- PRN
- q4
- q6
- q8

\_\_\_\_\_  
 Dosage prescribed at School

\_\_\_\_\_  
 Time of Scheduled Dose

\_\_\_\_\_  
 Frequency of Dose

\_\_\_\_\_  
 Printed Name of Licensed Physician

\_\_\_\_\_  
 Signature of Licensed Physician

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Telephone Number

\_\_\_\_\_  
 Date

**(THIS SECTION TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN.)**

I, \_\_\_\_\_, the parent or legal guardian of \_\_\_\_\_, request that he/she be assisted with the medication described on this form by a nurse or other authorized employee of the District. I understand the medication will not be given except as described in the physician's directions above. I hereby agree to hold the Saugus Union School District, it's officers, agents and employees harmless from any and all liability which may arise out of the District's performance under this agreement. I authorize the school nurse to communicate with the physician when necessary.

\_\_\_\_\_  
 Signature of Parent or Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Home Phone

\_\_\_\_\_  
 Emergency Phone

**REQUIREMENTS:**

- 1. All medication must be in the container originally supplied to the patient.**
- 2. This Agreement must be completed at the beginning of each school year as needed for ongoing prescriptions and for any changes in prescriptions during the school year.**