SAUGUS
Union School District
Excellence in Elementary Education

24930 Avenue Stanford, Santa Clarita, California 91355
Phone: 661-294-5300 / www.saugususd.org

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

Route

Dosage prescribed at School

Time of Scheduled Dose

Frequency of Dose

☐ q4 ☐ QD
☐ q6 ☐ PRN

Side effects

Physician's Stamp

Printed Name of Licensed Physician

Signature of Licensed Physician

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.**

Rev 1/17 SST/SG