POMONA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES & PROGRAMS

Medication & Special Procedure Sign Off

Student_____ Grade _____
School_____ Teacher _____

Check one:

_____Medication during school hours
_____Specialized health procedure during school hours

Physician's written order received on _____
Date

Parent permission request for assistance received on _____
Date

	MEDICATION	**DOSAGE**	**TIME**
1.	_____	_____	_____
2.	_____	_____	_____

SPECIAL HEALTH PROCEDURE: _____

_____

TIME SCHEDULE: _____

INDICATIONS/PRECAUTIONS:_____

_____

*The following district personnel acknowledges receiving instruction from the school nurse in providing the above service to this student. The school nurse will provide ongoing monitoring and supervision as determined by Section 3001(T) of the California Code of Regulations, Title 5, and Education.

	Print Name	**Signature**	**Initials**	**Instruction/Monitoring**
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

*Suggested individuals include health assistant, principal, office manager, clerk-typists, teacher

When this form is complete, place in front of the medication book.

Revised 07/13