Fallbrook Union Elementary School District
321 N. Iowa Street Fallbrook, CA 92028-2108 760.731.5400 www.fuesd.org
Candace Singh, Ed.D.
Superintendent

PHYSICIAN STATEMENT

This portion to be completed by school personnel: This form valid only for one year.

Name of student: ______________________________ Date of Birth: ____________________
Last First Middle Month / Day / Year

School: ______________________ Teacher: ____________________ Room: _______ Grade: ________

Location of medication (Building, Room Number, Cabinet): ______________________________

Person(s) authorized to assist student (Nurse, Secretary, Self): ______________________________

Who is to bring medication to school? (Name of person): ______________________________

How often will medication be brought to school? (Daily, Weekly, etc.): ____________ Type of container: ________________

The "Authorization for Medication Administration" form must also be completed by parent and returned to school along with this form.

This portion to be completed by a physician licensed in the state of California:

	Name of Medication	Method of Administration	Dosage	Time of Day
#1	___________	___________	______	________
#2	___________	___________	______	________
#3	___________	___________	______	________

Diagnosis: ____

Discontinue Medication #1 on: ______________ Medication #2 on: ______________ Medication #3 on: ______________
Date Date Date

Type of assistance for administering medication (Observe, Measure, etc.): ______________________________

Precautions for administering medication: ______________________________

Do you wish to have school personnel contact you at intervals to discuss this medication? Yes _________ No ___________

Please indicate person(s): ______________________________ Intervals: ______________________________
Teacher, Nurse, Psychologist, etc. Daily, Weekly, Quarterly, etc.

Asthmatic / Diabetics only:

Student must be supervised when taking medication Yes ____ No _____ This student may self carry: Yes ____ No ______

______________________________ MD ______________________ ______________________
Printed Name of Physician Phone Number Fax Number

______________________________ MD ______________________ ______________________
Physician Signature Date Medical License Number