PHYSICIAN INFORMATION FORM
WALDEN WEST OUTDOOR SCHOOL

(Give this form to your child's teacher)

Child's School:_______________________

Child's Teacher:______________________

INFORMATION REQUEST FORM FOR ALL MEDICATION TO BE DISPENSED WHILE YOUR CHILD IS AT WALDEN WEST

PART 1 TO BE COMPLETED BY CHILD'S PHYSICIAN
PART 2 TO BE COMPLETED BY PARENT OR GUARDIAN

In accordance with California Education Code, in order for your child to receive over-the- counter or prescription medication while attending the Walden West program, the following must be filled out and signed by your child's physician, and signed by you. The medication, with the completed form, must be turned in to your child's classroom teacher.

PART 1 TO BE COMPLETED BY PHYSICIAN

STUDENT:____BIRTH DATE:_____________________SCHOOL:________________________

Medication Name	Dosage	Route	Frequency	To Be Continued Until	Possible Reactions to Medication	Condition For Which Medication Is Being Given

PHYSICIAN'S NAME:__________________________________ DATE OF REQUEST:______________________________

PHYSICIAN'S SIGNATURE:____

PHONE NUMBER:____

ADDRESS:____

PART 2 TO BE COMPLETED BY PARENT

PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

I request that my child ________________________________be administered medication in accordance with the above information by a member of the Walden West or school staff. I understand that the medication to be taken during the Walden West program must be sent in a pharmacy labeled bottle or original packaging and I must notify the school if the medicine is to be changed or stopped. Medication will not be dispensed if it is not in the proper container.

I understand that the school is not legally obligated to administer medication to my child; therefore, I agree to hold the school district and its employees free from any or all suits which might arise out of these arrangements.

Parent's Signature:__________________________________Date:_________ Phone:____________________