OFFICE OF LARRY E. REIDER
KERN COUNTY SUPERINTENDENT OF SCHOOLS
1300 17th Street - CITY CENTRE
Bakersfield, CA 93301-4533

KERN ENVIRONMENTAL EDUCATION PROGRAM (KEEP)

TO: PARENTS & GUARDIANS

IF YOU ARE SENDING ANY MEDICINE TO KEEP WITH YOUR CHILD, PLEASE READ CAREFULLY

1. DO NOT send any substances your child can easily do without for the week. Send only those items which must be taken or may be needed in an emergency.

2. Students with insulin, injection kits for bee sting reaction, special dietary needs, epilepsy or any other serious health concern must notify the Director at the Kern County Superintendent of Schools Office for prior approval to attend KEEP. Special forms are available for students with special physical health care needs. Phone: (661) 871-1883.

3. Students cannot be given medication without a Pupil Medication form completely filled out by the parent and signed by both the parent and physician, for each medication.

4. Medication is defined as prescription and over-the-counter medicines such as aspirin, vitamins, Tylenol®, cough drops, etc.

5. All students that bring medication with them must turn it in to the KEEP staff.

6. Each medicine must be in the original container and marked with the student's name and school.

7. The KEEP staff will administer the medicine as per the physician's instructions. Please take time to completely fill out the medication form.

8. Students will not be allowed to carry any medication with them unless it is indicated on the medication form.

9. Up to three different medications can be specified on the reverse side of this form. Use an additional sheet for other medications to be administered. This form can also be found on-line at the KEEP website: www.campkeep.org.

(over)

OFFICE OF LARRY E. REIDER
KERN COUNTY SUPERINTENDENT OF SCHOOLS
1300 17th Street - CITY CENTRE
Bakersfield, CA 93301-4533

PUPIL MEDICATION TO BE ADMINISTERED AT KEEP SCHOOL

Student ______________________________ Date of Attendance ____________________

School ______________________________ Teacher ____________________

MEDICATION #1

Name of Medicine ______________________________

Strength ____________________ (mg., tsp.) Dosage ____________________ (# of tablets, tsp.)

Schedule of Administration:

☐ If daily, when? ______________________________

☐ If as needed, under what conditions? ______________________________

Comments: ______________________________

Physician's Signature: ______________________________ phone #: ____________________

Parent/Guardian Signature: ______________________________ phone #: ____________________

MEDICATION #2

Name of Medicine ______________________________

Strength ____________________ (mg., tsp.) Dosage ____________________ (# of tablets, tsp.)

Schedule of Administration:

☐ If daily, when? ______________________________

☐ If as needed, under what conditions? ______________________________

Comments: ______________________________

Physician's Signature: ______________________________ phone #: ____________________

Parent/Guardian Signature: ______________________________ phone #: ____________________

MEDICATION #3

Name of Medicine ______________________________

Strength ____________________ (mg., tsp.) Dosage ____________________ (# of tablets, tsp.)

Schedule of Administration:

☐ If daily, when? ______________________________

☐ If as needed, under what conditions? ______________________________

Comments: ______________________________

Physician's Signature: ______________________________ phone #: ____________________

Parent/Guardian Signature: ______________________________ phone #: ____________________

Please copy this form if needed.

(over)