

Rosedale Union School District
2553 Old Farm Road
Bakersfield, California 93312
(661) 588-6000 • FAX: (661) 588-6009

REQUEST FOR SPECIAL CONSIDERATION DURING SCHOOL HOURS
(Complete on school entry each year)

Student's Name _____ Date of Birth _____
School _____ Teacher _____ Grade _____
Parent's Name _____ Address _____ Phone _____
Condition(s) _____ School Year _____

Dear Parent:

You have indicated that this student has a condition which may require special consideration during school hours. For the most part, school personnel will try to safely minimize the effects of this condition by helping the student fit into the regular school routines. However, in order to act in his/her best interests, we are requesting more information.

A brief history of the condition(s): _____

Primary Physician: _____ Phone: _____ Fax: _____

Address: _____

Symptoms which could develop in the school setting:

Parents would like this response from school personnel:

Medications taken regularly (include medications taken during and after school hours): (C.E.C. 49480)

<u>Name of Medication</u>	<u>Dosage</u>	<u>Time of Day When Taken</u>	<u>Prescribing Physician</u>
1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____

(FOR MEDICINE TO BE GIVEN DURING SCHOOL HOURS, REQUEST MEDICATION FORM, 9-3)

We agree to mutual sharing of information by our doctor and the school personnel about our child's need for the medication and the expected effects and side effects.

Parents: Please keep emergency information at the school updated. Feel free to contact the school secretary, child's teacher, school principal or district nurse if additional assistance is needed and return both copies as soon as possible. Thank you for your cooperation.

Parent Signature: _____ Date: _____