



**MEDICATIONS DISPENSED IN SCHOOL**

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE/Trk: \_\_\_\_\_ TEACHER: \_\_\_\_\_

Medication may be dispensed to students at school if the following information is completed and the parent/guardian agrees to the following terms and conditions. *Note: This form is valid for one year. Ed Code 49423, CA State Child Community Licensing*

**Parent /Guardian Consent:** I understand the following:

- Any pupil who is required to take medication prescribed by a health care provider may be assisted by a school nurse or other designated school personnel. This accommodation is provided only when the schedule of medication would otherwise require the pupil to remain home, when medication is needed for emergency situations, or for specific health reasons. As a parent, I have the right to come to school and administer medication to my child if I feel it is necessary. Students may self-administer medication at school when the parent, health care provider & school nurse determine student is competent to do so.
- Parent is required to bring the medication to school (Infant - 8<sup>th</sup> grade), and to pick up any unused medication at the end of the school year. Those medications not picked up will be destroyed.
- Medication administered at school must be provided in its pharmacy labeled bottle or in original pharmacy labeled injectable medication kit. The label shall state: student's name, date, name of medication, dosage, time(s) to be given, special instructions, and health care provider's name. Parent must provide appropriate dosage measuring device, especially for liquid medication.
- Over-the-counter remedies, nutritional supplements and herbal remedies must remain in manufacturer's container and be marked with student's name.
- Parent/Guardian may terminate consent for medication administration by informing the school in writing.
- The school is not legally obligated to provide this service and cannot be held responsible for missed, or refused doses, side effects caused by the medication or any other problems. In return for the school district's assistance in administration of medication, I hereby waive any claim for injury against the school district, or its employees, arising from the administration of medication.
- Parent signature authorizes the school nurse to communicate with the health care provider when necessary.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone (home): \_\_\_\_\_ (Work): \_\_\_\_\_

**Parent** It is my parental opinion that my child should be allowed to carry and use this medication (i.e. asthma inhaler, insulin, epinephrine) by him/herself. Yes  No

**TO BE COMPLETED BY HEALTH CARE PROVIDER**

Name of Medication (as prescribed): \_\_\_\_\_

Dosage: \_\_\_\_\_ Method of Administration: \_\_\_\_\_

Time(s) to be dispensed at school: \_\_\_\_\_ Duration: \_\_\_\_\_

Health condition for medication: \_\_\_\_\_

Special instructions/precautions: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

**Health Care Provider** It is my professional opinion that this child should be allowed to carry and use this medication (i.e. asthma inhaler, insulin, epinephrine) by him/herself. Yes  No

Any change in medications, dosage, or time can be authorized on your prescription blank and mailed to the school. The current authorization will be effective for one school year.

Health Care Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

01/06/2004

**School Nurse** It is my professional opinion that this student \_\_\_\_\_ should be allowed to carry and use his/her medication by him/herself. Yes  No