Please complete and return to the Health Clerk at school site

FREMONT UNION HIGH SCHOOL DISTRICT

Authorization for Student to Carry Medication in School

PART 1 - STUDENT INFORMATION

Student's Legal Last Name	Student's Legal First Name	Birth Date	Grade	School Year

PART 2 – COMPLETED BY PHYSICIAN

I certify that the above named student must carry the following with him/her at all times while at school and school related activities:

Name of Medication(s)	Medical Condition Requiring Listed Medication(s)

Observable Adverse reaction(s) that might be observable at school:

Please check each of the following with an X to verify the accuracy of the statement:

- ☐ This condition is such that there is inadequate time for the student to go to the office to obtain the medication.
- ☐ I have instructed the student in the proper administration of this medication and have certified that he/she needs no adult supervision. I have further instructed the student in the dangers of giving the medication to anyone other than himself/herself. I have discussed the above stated risks and liabilities with the parent.

Physician's Printed Name	Physician's Signature	Date

Physician's CA License Number	Physician's Address	Phone Number

PART 3 – COMPLETED BY PARENT

I permit my son/daughter to carry the above listed medication as ordered/approved by his/her physician or surgeon. I authorize the school nurse or other designated school personnel to consult with my child's health care provider regarding any questions that may arise with regard to the medication. My child's physician has fully instructed my son/daughter on the proper administration of this medication, and I certify that he/she does not need adult supervision. I accept responsibility for the appropriate use of this medication by my son/daughter. I am aware of the risks to my son/daughter and other students and assume responsibility for any liability related to the misuse of this medication. I agree to hold the school district and its employees free from any and all responsibility for such services or the manner in which it is administered.

Parent's Signature	Date	Phone Number

PART 4 – COMPLETED BY STUDENT

I have read and understand the medication information above. I will use my medication as I have been instructed and trained by my physician or surgeon. I will keep my medication on my person or in my possession at all times and I will not let anyone else handle or use my medication.

Student's Signature	Date	Phone Number