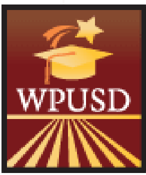


WESTERN PLACER UNIFIED SCHOOL DISTRICT

600 Sixth Street, Suite 400, Lincoln, CA 95648 Ph: 916-645-6350

Administration of Medication Form

Student Name: ______________________________________ Date of Birth: _____________

School: __________________________ Grade: _________ Teacher: _________________

PARENT/GUARDIAN

PARENT/GUARDIAN RESPONSIBILITIES AND STATEMENT

I, as a parent or legal guardian of the above listed student, request and understand the following in accordance with California Education Code sections 49423-49423.5 and the Department of Education in order for the student to take medication during school hours, school activities and field trips:

- My student will not be assisted with medication at school until all requirements are met.
- I shall provide a new written authorized health care provider's statement with any changes in medication, dose, medical provider, time or discontinuation of medication.
- I understand that a school nurse is not on campus daily. During his/her absence, a designated unlicensed trained school staff employee will administer or otherwise assist my student in the administration of below prescribed or over the counter medication.
- Medication will be taken on all school activities and field trips during school hours unless otherwise directed.
- All medication must be brought to the school by a parent/guardian in the original container, with a pharmacy label if applicable.
- If agreed on by the students health care provider, I consent to allow my child to carry and self-administer the below medication and release the district and school personnel from civil liability if my student suffers an adverse reaction as a result of self-administering the medication.
- This request for medication administration can be terminated at any time or for otherwise assisting the student in the administration of medication at any time.

_________________________ _____________________ ___________

Signature of Parent/Legal Guardian   Printed Name   Date

HEALTH CARE PROVIDER

HEALTH CARE PROVIDER STATEMENT (To be completed by health care provider)

The child named above is under my care for the following medical diagnosis: ________________________

Medication	Dose	Route	Time or Frequency	Duration
☐ Scheduled ☐ PRN				
☐ Scheduled ☐ PRN				

For PRN medication: Symptoms that would necessitate administration: ________________________________

Indications for referral for medical evaluation: ____

Precautions or side effects: ____

☐ **I confirm that it is medically necessary for the student to carry this medication on campus, and indicate one of the following:**

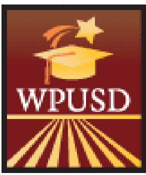
☐ Designated school personnel to administer to student

☐ Student has been trained by healthcare provider to self-administer

_________________________ ___________

Signature of Health Care Provider   Date

Health Care Provider name/address/phone:



WESTERN PLACER UNIFIED SCHOOL DISTRICT

600 Sixth Street, Suite 400, Lincoln, CA 95648 Ph: 916-645-6350

Administración del Formulario de Medicamentos

Student Name: ____ Date of Birth: ______________

School: ____________________________ Grade: __________ Teacher: __________________

PADRE/TUTOR LEGAL

DECLARACION Y RESPONSIBILIDADES DE LOS PADRES/TUTORES

Yo, como padre o tutor legal del estudiante enumerado arriba, solicito y entiendo lo siguiente, según el Código de Educación de California secciones 49423-49423.5 y el Departamento de Educación en orden para que el estudiante tome medicamento durante las horas escolares, actividades escolares y viajes de campo:

- Mi estudiante no será asistido con medicamentos en la escuela hasta que todos los requisitos sean cumplidos.
- Debo proporcionar un nuevo escrito declaración autorizada del médico con los cambios en la medicación, dosis, proveedor medico, tiempo, o discontinuación de la medicación.
- Entiendo que una enfermera de la escuela no está en la escuela diariamente. Durante sus ausencia, un empleado de personal entrenado sin licencia designado de la escuela administrara o, a lo contrario, asistirá a mi estudiante en la administración de abajo prescrita o sobre los medicamentos sin receta.
- La medicación se tomara en todas las actividades escolares y excursiones durante el horario escolar a menos que se indique lo contrario.
- Todos los medicamentos se deben traer a la escuela por un padre o tutor en el envase original, con una etiqueta de la farmacia si es aplicable.
- Si acordado por el proveedor de cuidado de salud, doy mi consentimiento para permitir que mi hijo lleve y auto administre el medicamento, enumerado abajo, y libero de responsabilidad civil el distrito y el personal de la escuela, si mi estudiante sufre una reacción adversa como consecuencia de la auto-administración de la medicación.
- Esta solicitud de administración de medicamentos puede ser terminada en cualquier momento o de lo contrario asistir al estudiante en la administración de la medicación en cualquier momento.

______________________ ___________________________ ____________

Firma del padre/tutor Nombre en Letras de Imprenta Fecha

HEALTH CARE PROVIDER

HEALTH CARE PROVIDER STATEMENT (To be completed by health care provider)

The child named above is under my care for the following medical diagnosis: ___________________________

Medication	Dose	Route	Time or Frequency	Duration
☐ Scheduled ☐ PRN				
☐ Scheduled ☐ PRN				

For PRN medication: Symptoms that would necessitate administration: ______________________________

Indications for referral for medical evaluation: ____

Precautions or side effects: ____

☐ **I confirm that it is medically necessary for the student to carry this medication on campus, and indicate one of the following:**

- ☐ Designated school personnel to administer to student
- ☐ Student has been trained by healthcare provider to self-administer

Health Care Provider name/address/phone:

___________________________ ____________

Signature of Health Care Provider Date