COAST UNIFIED SCHOOL DISTRICT

Health and Safety

PARENT RELEASE FOR THE ADMINISTRATION OF MEDICINE

Return this form to Student's School

Coast Unified School District:
School: _____
Date: _____

Education Code Section 49423 states: Notwithstanding the provisions of section 49422, any pupil who is required to take, during the regular school day, medication of him by a physician may be assisted by the school nurse or designated school personnel if the school district receives (1) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

We, the undersigned, who are the parents/guardian of_____ request that medicine be administered to our child by the designated member of the school staff as advised in the written instructions, from our physician,

_____ _____ _____
Physician Name Phone Number Fax

We understand that the school is not legally obligated to administer to any child and therefore agree to hold the school district and its employees harmless from any and all liability for the results of such medication or manner in which it is administered, and to indemnify the school districts and its employees for any liability arising out of this arrangement. We will notify the school immediately if the medication is to be changed or discontinued or if we change physicians.

_____ _____
Parent/Guardian Signature Parent/ Guardian Signature

_____ _____ _____
Home Phone Work Phone Cell Phone

_____
Address

Low cost insurance is available for low to middle income families, through Medic-Cal. Our schools have information and Health Department can assist you in applying for this insurance. For more information, call 1-888-747-1222.

PHYSICIAN AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY DESIGNATED SCHOOL PERSONNEL AUTHORIZATION TO ASSIST IN ADMINISTRATION OF MEDICATION

Student Name_____ Date of Birth: _____
Physical Condition for which medication is given: _____
Name of Medication: _____ Dose: _____
(Please complete separate form from EACH medication to be taken at school)
Schedule of Doses:_____

Precautions, possible, and interventions: _____

_____
This medication is to be continued as above until: _____

_____
Print Name

_____ DATE: _____
Signature of Physician

This student is capable of self-administration under supervision. Yes: _____ No: _____

Physician Name (Print of type):_____ Phone: _____

Physician Signature: _____ Date: _____