SAN MATEO-FOSTER CITY SCHOOL DISTRICT

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Students Name: _____ Birthdate: _____

Teacher: _____ Grade: _____ School: _____

SELF-ADMINISTRATION PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION

TO BE COMPLETED BY PHYSICIAN OR OTHER HEALTHCARE PROVIDER LICENSED BY THE STATE OF CALIFORNIA TO PRESCRIBE MEDICATION

Inhaler _____ EpiPen _____ Glucagon _____ Insulin _____ Other (diabetes related) _____

The child named above is under my care and needs to carry this medication with him/her while at school. I agree that the child is capable of self-administration and is able to manage this medication responsibly.

STUDENTS NAME (PRINT): _____

DIAGNOSIS FOR WHICH THE MEDICATION IS PRESCRIBED: _____

MEDICATION NAME: _____

Dosage: _____ Time: _____ Route: _____

IF DOSAGE IS AS NEEDED (PRN), THE SYMPTOMS THAT NECESSITATE ADMINISTRATION AND ALLOWABLE FREQUENCY: _____

_____

ESTIMATED TERMINATION DATE: _____

POSSIBLE SIDE EFFECTS: _____

This child's health requires that the above medication be taken during school hours and this child is capable of self-administration of the medication.

DATE: _____ PHYSICIAN: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

PHYSICIAN/CLINIC STAMP: _____

I hereby give permission for school personnel to administer medication to my child during the school day as prescribed by the child's physician.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

IN CASE OF EMERGENCY, PHONE NUMBER I CAN BE REACHED AT: _____

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