Valley Center Public Schools USD 262
Medication Administration Release Form

I hereby certify that __________________________ Date of Birth ___________ GR_____ School Year ________has previously had a least one dose of the prescribed medication listed and did not have an adverse reaction from it. I request that this medication(s) to be administered at school as prescribed by the physician. I understand that any school employee who administers this prescription to my child in accordance with written instructions from the physician or dentist (and USD 262 Board of Education Policy) shall not be liable for damages as a result of an adverse drug reaction suffered by pupil, because of administering such a drug or because of a mislabeled or altered product. I hereby authorize USD 262 Department of Health Services personnel to receive or exchange information regarding dispensing and monitoring of this medication with _________________, the attending physician or dentist, or with the pharmacy as identified on the label of the prescribed medication container.

____ ________________ ________________

Parent Signature **Date** **Phone Number**

REQUEST FOR ADMINISTRATION OF MEDICATION

Name of Medication ____

Purpose/Diagnosis for Taking Medication____

Prescribed Dosage/Direction and Times for Administering at School_________________________________

Additional Special Instructions or Circumstances____

Duration of Treatment (please check appropriate box) ☐ For current school year

☐ For specified period of time: ______________to_______________

____ ________________ ________________

Physician's signature ***(required for prescription medications only)*** **Date** **Phone Number**

____ ________________ ________________

Parent's signature ***(Required for both prescription and non-prescription medications)*** **Date** **Phone Number**

REQUEST TO SELF ADMINISTER MEDICATION
GRADES 6-12- DIABETES, ASTHMA/ANAPHYLACTIC REACTION

I request that my child be permitted to self-mediate at school for the treatment of symptoms related to diabetes, asthma or anaphylactic reaction. I request that my child be permitted to carry the medication with him/her. I understand my child will be responsible for knowing the location of the medications at all times. I acknowledge that the school district and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from the self-administration of medication and indemnify and hold the school and its officers, employees and agents, harmless from and against any claims relating to the self-administration of such medication. I confirm that my child has been instructed on the proper use of this medication and is able to self-administer this medication on his/her own without school personnel supervision. The student understands the expected response to the medication and what side effects and adverse responses should be reported to an adult. I have provided a written treatment plan for use managing asthma, anaphylaxis episodes, or for a chronic health condition. I have read the Medication Policy for Valley Center USD 262. A request for Administration of Medication at School form must be completed. This serves as written notification in accordance with board policy JGFGBA.

The student has demonstrated to the health care provider and the school nurse the skill level necessary to use the medication as prescribed in accordance with the health care providers written treatment plan.

I have discussed the following conditions with my child:

1. Immediately tell an adult when having breathing problems or a reaction.
2. Never share medication with anyone else.
3. Have prescription label on medication.

____ ________________ ________________

Physician's Signature **Date** **Phone Number**

____ ________________ ________________

Parent's Signature **Date** **Phone Number**