Dry Creek Joint Elementary School District

Health Services
ADMINISTRATION OF MEDICATION

This form valid for school year_____ to_____

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

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 administration or be able to self-carry medication until all requirements are met.
- Prescription and nonprescription medications are not permitted to be taken at school without meeting the below requirements
- I will notify the school immediately if there are any changes in the below medication order. Any changes to the original form on file requires a new form to be competed and turned in to the office before continued medication can be administered.
- I understand that this form must be completed annually, even when there are no changes to the below medication order.
- I understand that 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.
- I grant permission to health services staff to discuss with school personnel my student's health condition and medication.
- I grant permission to health services staff to communicate directly with my student's health care provider or pharmacist for clarification and further information regarding this medication.

Assistance by School Personnel:

- I ☐ DO ☐ DO NOT request the district to assist my student in taking the medication as prescribed by the Authorized Health Care Provider. I understand that a school nurse is not on campus daily and in his/her absence designated and trained school personnel will assist with the medication administration.
- I will ensure medication is delivered, by an adult, in a properly labeled pharmacy bottle containing the name and telephone number of the pharmacy, the student's identification, name of the provider, dose of medication and expiration date.
- Medications under the jurisdiction of the Federal Controlled Substance Act (e.g. Ritalin and Phenobarbital) must be transported to and from school by parent/guardian or an adult parent/guardian designee. Controlled drugs shall be counted, upon their arrival in school, by the designated trained school staff in the presence of the parent/guardian. The date, number of pills, and the signature of the designated school staff shall be entered into the medication log.
- Medication will be taken on all school activities and field trips during school hours unless otherwise directed.

Self-Administer & Carry:

- I ☐ DO ☐ DO NOT request, if agreed on by my students authorized health care provider below, that my student be allowed to self-administer, monitor or treat his/her existing medical condition. I understand the school will not be responsible for the loss or inappropriate use of carried medication. I release the school district and school personnel from civil liability if the student suffers from any adverse reaction by taking self-administered medication. Sharing of medication with other student students will result in disciplinary action.

_____ _____ _____

Signature of Parent/Legal Guardian Printed Name Date

Dry Creek Joint Elementary School District

Health Services
ADMINISTRATION OF MEDICATION

This form valid for school year_____ to_____

_____
Student Name

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

The student named above is under my care for the following medical diagnosis: _____

_____

Student has been prescribed the following medication: _____

Medication	Dose/Amount	Route/Method	Time/Frequency	Duration
☐ Scheduled ☐ PRN		☐ PO ☐ IM ☐ Inhalation ☐ Other:_____		

For PRN medication: Symptoms that would necessitate administration: _____

Indications for referral for medical evaluation: _____

Precautions or side effects: _____

Student was instructed in the use, safety, and need for medication ☐ Yes ☐ No

Student is competent to carry and self-administer medication ☐ Yes ☐ No

Student may carry medication but needs assistance with administration ☐ Yes ☐ No

If student needs assistance with administering medication, a trained unlicensed assistive person/trained health care aide may administer the prescribed medication*. ☐ Yes ☐ No

If student cannot self-administer medication, a trained unlicensed assistive person/trained health care aide may administer the prescribed medication*. ☐ Yes ☐ No

Other recommendations: _____

(To be completed by health care provider)

☐ As the prescribing physician, in the event there is no school nurse or other licensed person to administer medication, I authorize/agree a trained unlicensed assistive person/trained health care aid to/may administer the prescribed medication to the above student.

☐ As the prescribing physician, I authorize/that student may administer the prescribed medication to the above student.

_____ _____
Physician's Printed Name Phone/FAX

_____ _____
Physician's Signature Date

_____
Address (Street, City, State, Zip)

*Note: Parental consent is also required under Education Code 49423(b)(1).