



# OAKDALE JOINT UNIFIED SCHOOL DISTRICT

District Office 168 South 3<sup>rd</sup> Avenue (209) 848-4884 Fax: (209) 847-0155

STUDENT  
PICTURE  
HERE

## Request for Medication Administration During School Hours (English)

Student: \_\_\_\_\_ DOB: \_\_\_\_\_  
Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Approved by School Nurse:  
\_\_\_\_\_ Date: \_\_\_\_\_

### TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER CALIFORNIA CODE OF REGULATIONS TITLE 5, SECTION 601(A)

*\*Self-Administration ONLY for Auto-Injectable Epinephrine, Inhaled Medication, and Diabetes Medication*

DX/REASON	MEDICATION	DOSE	ROUTE	TIME	SIDE EFFECTS	For as needed meds, symptoms allowing administration	To be kept in the health office	*Student may self-carry and self-administer

If indicated (checked) above, I give permission for the above student to carry and self-administer medication. I have confirmed that the student is capable of appropriate self-administration. If the student is younger than 18, the parent/guardian assumes all liability related to this student's use, timing and technique in self-administering this medication. Other medication(s) will be kept and administered accordingly.

I understand that specialized physical health care services may be performed by unlicensed/non-medical designated school personnel under the training and supervision provided by the school nurse or other health care professional.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: (Please Print) \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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### TO BE COMPLETED BY PARENT/GUARDIAN

I request that my child be allowed to take medication during school hours according to the instructions from his/her Physician. I understand it is my responsibility to **bring the medication to school in the original pharmacy container, labeled with the child's name, medication, dosage and directions** (Ed Code 49423) and to notify the school if the medication has changed or is no longer needed. I authorize the school personnel to assist with the above medication for my child, as ordered by the physician listed above. I understand that non-medical school personnel may assist with this medication (Ed Code Sec 49423 and 49480). I give permission for the exchange of information between the practitioner and/or pharmacist and the school nurse or designee to ensure the safe administration of listed medication(s). **I understand this form must be updated annually and whenever the prescription changes.** I understand medication will be destroyed one week beyond the end of school if not picked up.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Daytime Phone Numbers: \_\_\_\_\_ and \_\_\_\_\_

STUDENT CONTRACT FOR CARRYING OWN MEDICATION: I \_\_\_\_\_ will be responsible for carrying, administering, and keeping safe at all times, my medication. I will use the medication in the way prescribed by my physician. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing.