Turlock Unified School District

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Please fax or return form to the School Health Office.

Student: _____ Birth Date _____ Male ☐ Female ☐

School: _____ Teacher: _____ Grade _____

School FAX: _____ School Phone: _____

TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER

(Make copies if more than one medication is required.)

Medication Name: _____ Strength (mg, ml, mcg): _____

Dose (3 of tab, puffs, etc.): _____ Method of Administration _____

Time of Administration: _____

Start: Immediately_____ Other Date_____ Stop_____ End of Year_____ Other Date/Duration _____

PRN (prescribed as needed)**:** Symptoms _____

Reason for Medication: _____

Restrictions and/or important side effects: ____None Anticipated _____Yes, please describe _____

REQUEST FOR SELF-ADMINISTRATION OF INHALER AND EPI-PENS OR INSULIN

This student is both capable and responsible for self-administering auto-injectable epinephrine, inhaled asthma medication/insulin

_____Yes, unsupervised. _____Yes, supervised. _____No, please indicate additional information: _____

Health Care Provider's Name: _____

Health Care Provider's Signature: _____ Date: _____

Fax#: _____ Phone#: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

PARENT/GUARDIAN CONSENT FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

Parent(s) guardian(s) of _____ request that medication be administered by the school nurse or a member of the school staff if the school nurse is not available. I consent to allow disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel. I will notify the school if the medication has changed or is no longer needed. Medication will be furnished in its pharmacy-labeled container.

Parent/Guardian signature: _____ **Date:** _____ **Phone#:** _____

PARENT/GUARDIAN CONSENT FOR SELF-ADMINISTRATION OF MEDICATION

FOR AUTO-INJECTABLE EPINEPHRINE OR INHALED ASTHMA MEDICATION

I hereby consent for my child, _____, to self-administer the following medication during the regular school day or when attending school-related activities: _____Auto-injectable epinephrine _____Inhaled asthma medication

I also consent to disclose identifiable health information by the health care provider to the school nurse or other personnel designated by Turlock Unified School District

I acknowledge that I have an obligation to notify the school if my child's medication, dosage, frequency of administration or reason for administration changes during the school year.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to indemnify and hold harmless, release and covenant not to sue the District, it's officers, employees, and agents, for any and all liability, claim or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self-administration of medication

Parent/Guardian Signature _____ **Date:** _____ **Phone#:** _____