ADMINISTRATION OF MEDICATIONS DURING SCHOOL HOURS/DAY/FIELD TRIPS **School Year**:_____

Portola Valley School District
4575 Alpine Road, Portola Valley, CA 94028
(650) 851-1777 ▪ FAX (650) 851-3700

School:_____

School Fax:_____

This form must be completed before any prescription or over-the-counter medication will be administered at school.

Student Name:_____ DOB:_____

TO BE COMPLETED BY AN AUTHORIZED CALIFORNIA HEALTH CARE PROVIDER California Code of Regulations Title 5, Section 601(A)

CONTROLLED MEDICATIONS INCLUDING ANTI-DEPRESSANTS MAY NOT BE CARRIED

DRUG	DOSE	ROUTE	TIME	DIAGNOSIS	STUDENT CARRY
					YES ☐ NO ☐
					YES ☐ NO ☐
					YES ☐ NO ☐
					YES ☐ NO ☐

I give permission for the student to carry and self-administer medication checked above. The health care provider has confirmed that the student is capable of appropriate self-administration of the above medication. If the student is younger than 18, the parent/guardian assumes all liability related to this patient's use, timing and technique in self-administering this medication.

Physician Signature: _____ Date: _____

Physician Name (please print): _____

Telephone: (_____) _____ Fax: (_____) _____

TO BE COMPLETED BY PARENT/GUARDIAN

☐ I request that my child be allowed to take medication at school according to the instruction 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). Determination of the request will be reviewed by the School Nurse.

☐ I authorize school personnel to assist with the above medication for my child as ordered by the physician listed above. I understand that trained, non-medical school personnel may assist with medication. (Ed Code 49423 and 49480)

This form must be renewed whenever the prescription changes and at the beginning of each school year.

While the school will make every effort to cooperate, the student must assume responsibility for coming to the office for the medication.

Parent/Guardian Signature:_____ Date:_____

Daytime Phone Numbers: _____ _____ _____
(Home) (Business) (Cell)

STUDENT CONTRACT FOR CARRYING OWN MEDICATION: I, _____(print) 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 others students. I will immediately report to persons in charge if my medication is missing. _____ Signature _____ date