CUPERTINO UNION SCHOOL DISTRICT
10301 Vista Drive Cupertino, CA 95014

Teacher: _____
Grade: _____
School: _____

MEDICATION FORM

Parent Authorization and Release for the administration of medication at school

Student Name: _____ DOB: _____

To be completed by physician or healthcare provider licensed by the state of CA to prescribe medication:

Diagnosis for medication prescribed: _____ Medication prescribed: _____ Dosage: _____ Time: _____ Route: _____ Frequency: _____ Termination Date: _____ Possible Side Effect: _____ _____	Diagnosis for medication prescribed: _____ Medication prescribed: _____ Dosage: _____ Time: _____ Route: _____ Frequency: _____ Termination Date: _____ Possible Side Effect: _____ _____
Diagnosis for medication prescribed: _____ Medication prescribed: _____ Dosage: _____ Time: _____ Route: _____ Frequency: _____ _____ Termination Date: _____ Possible Side Effect: _____ _____	Diagnosis for medication prescribed: _____ Medication prescribed: _____ Dosage: _____ Time: _____ Route: _____ Frequency: _____ _____ Termination Date: _____ Possible Side Effect: _____ _____

The child named above is under my care. It is necessary for him or her to receive the above, prescribed medication during school hours. A trained, non medical school employee or chaperone under the supervision and direction of the School Nurse may administer this medication. I understand that the School Nurse may not be present during administration of the medication.

Physician Signature _____ **Date** _____

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Teacher: _____
Grade: _____
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MEDICATION FORM

Parent Authorization and Release for the administration of medication at school

Student Name: _____ DOB: _____

To be completed by parent/guardian:
I give permission for school personnel to administer medication to my child during the school day as prescribed by the child's physician. Medications prescribed by my child's physician that are to be administered during school hours are listed on page one (the front of this form).

Signature of parent/guardian: _____ Date: _____

PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

California Education Code Section 49423 allows the school nurse or other trained, non-medical school personnel to assist students who are required to take medication during the school day, provided that appropriate authorization is given. In addition, Cal. Ed. Code, § 49423; 5 CCR § 604 allows parents/guardians to designate non-school personnel such as a trained chaperone to administer medication on a field trip.

I hereby give permission for school personnel and/or trained chaperone to administer medication to my child during the school day as prescribed by my child's physician.

Parent/Guardian Signature _____ **Date** _____

"Medication" includes prescription medication, over-the-counter medication, nutritional supplements and herbal remedies. Parents are responsible for providing all medication, supplies, and equipment necessary to administer the medication. No medications, including over-the-counter medications, will be given without a prescription. The medication prescription must be current and the medication must be supplied in the original package or original prescription bottle with the pharmacy label attached (ask your pharmacist to divide the medication into two bottles completely labeled: one for home and one for school). The medication must be prescribed to the student to whom it will be administered, and all medication containers must include a label with the student's name, physician's name, name of the medication, and the directions for use.

I authorize and hereby request that designated trained school personnel and/or non-school personnel such as a trained chaperone to assist my child in taking this prescribed medication (including prescribed over-the-counter medication, nutritional supplements, and herbal remedies) as prescribed by my child's health care provider. I agree to, and do hereby release and hold the District and its employees, chaperones, and contractors harmless from any and all claims, demands, causes of action, liability or loss of any type, because of or arising from acts or omissions with respect to this medication and agree to indemnify each of them with regard to any judgment or claim rendered against them arising out of this medication administration arrangement. I understand that my child may not have or take medication at school unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's health care provider and counsel school personnel as needed with regard to this medication.

_____	M F	_____
Student's Name (Print)	Sex	Date of Birth

I have read and understood the above authorization and release. I will immediately notify the school if there is any change in medication my child is taking at school. I also understand that this authorization is in effect for a maximum of one school year, and the District will require a new authorization at the beginning of each school year, or if any changes in prescription occur.

_____	_____
Date	Signature of Parent or Legal Guardian

Home Telephone: _____ Work Phone: _____ Cell Phone: _____