FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT HEALTH SERVICES

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

PLEASE NOTE: THIS FORM MUST BE COMPLETED EACH SCHOOL YEAR FOR EACH MEDICATION

POLICY GOVERNING THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL
Board Policy 5141.21

The Governing Board recognizes that some students may need to take medication prescribed by a physician during the school day in order to be able to attend school. The Superintendent or designee shall develop processes for the administration of medication to such students by school personnel

BASIC LEGAL PROVISION-California Education Code, Section 49423; 5 CCR 600

Prescribed medication may be administered by the school nurse or other designated trained school personnel only when the Superintendent or designee has received written statements from both a student's physician and parent/guardian.

PARENT REQUEST FOR ADMINISTRATION OF MEDICINE PRESCRIBED BY A PHYSICIAN

Student's Name _____ Birthdate _____ Grade _____School _____

We the undersigned, who are the parents/guardian of _____ request that a designated member of the school staff, in accordance with instructions administer medicine during school hours to said child in accordance with the instructions outlined below and signed by our physician.

In agreeing to have the school administer our son's/daughter's medication, I voluntarily agree to release, discharge, and hold harmless Folsom Cordova Unified School district and its officers, agents, and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which causes our child's illness, injury, death, and damages of any nature in any way connected with the administration of our child's medication.

We understand that the major responsibility for a child taking medication rests with the child and his/her parents or guardian and that we are required to personally bring the medication to school (preschool through 6th grade). With the exception of controlled substances, we understand that students in grades 7 through 12 may bring their own medication to the school office.

Parent's/Guardian Signature: _____ **Date**: _____

Parent's name (please print): _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact: _____ Phone: _____

PHYSICIAN'S INSTRUCTIONS - Please note: School Nurses are not always available on the school campus. Whenever possible please prescribe medication that can be given outside of the school day. If medication **must** be administered during school hours, please complete the information below:

Medication: _____ Dosage: _____ Approximate Time of Day: _____

Method or Route of Administration: _____ Length of Time to be Taken: _____

Physician's Instructions/Possible side effects of medication: _____

_____

Will student need to personally carry this medication? Yes ☐ No ☐ (may not carry controlled substances)

Will student be "self-administering" this medication? Yes ☐ No ☐ (excluding controlled substances)

Physician's Signature: _____ **Date** _____

Physician's Name (Please Print): _____

Address: _____ Office Phone: _____ Fax Number: _____

Student's Name ____ School___________________ Grade ______

Medication ____ Dosage _________________________

Monday			**Tuesday**			**Wednesday**			**Thursday**			**Friday**		
Date	Time	Init.	Date	Time	Init.	Date	Time	Init.	Date	Time	Init.	Date	Time	Init.
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Prescription Medication Log