

FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT HEALTH SERVICES

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Please Note: This form must be completed each school year for each medication.

I. 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.

II. 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/Guardian Signature(s):

Print Name(s): Date:

Home Phone Work Phone: Cell Phone:

Emergency Contact: Phone:

V. 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 Name (Please Print):

Physician’s Signature: Date

Address: Office Phone: Fax Number:

FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT HEALTH SERVICES

AUTHORIZATION FOR THE ADMINISTRATION OF NON-PRESCRIPTION OVER-THE-COUNTER MEDICATION IN SCHOOL

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

Student's Name _____ Birthdate _____ Grade _____ School _____

My child will need to take non-prescriptive, over- the-counter medication during school hours. I understand that non-prescription medication shall be brought to the school office in the original container(s) and labeled with my student's name.

We the undersigned, who are the parent(s)/guardian(s) of _____ request that non-prescriptive, over-the-counter medicine be administered to said child by a designated member of the school staff in accordance with instructions outlined below.

I agree as soon as my child no longer needs to take this non-prescriptive, over- the- counter medication, I will notify the school and personally retrieve the medication from the school office.

In agreeing to have the school administer our son's/daughter's over- the- counter 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/guardians, and that we are required to personally bring the medication to school (preschool through 6th grade). We understand that students in grades 7 through 12 may bring their own to the school office.

Please note: School Nurses are not always present on the school campus. Whenever possible please administer over-the-counter medications outside of school hours. If over-the-counter medication must be administered during school hours, please complete the information below:

Diagnosis or indication for medication: _____

Medication: _____ Dosage: _____ Approximate time : _____

Method or route of administration: _____ Length of time to be taken _____

Precautions (please note side effects of this medication): _____

Instructions: _____

Parent's name (please print): _____

Parent's Signature: _____ Date _____

Home Phone _____ Work Phone _____ Cell Phone _____