Tamalpais Union High School District ~2022-2023 School Year

AUTHORIZATION TO ADMINISTER MEDICATION/TREATMENT
AND AUTHORIZATION TO RELEASE INFORMATION TO PHYSICIAN

Student: _____ Phone:_____ Date:_____

Grade:_____ Physician:_____ Physician's Phone:_____

MEDICATIONS: (Keep medication in original container*)

Medication	Dose	Time	Instructions (including method)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional information and or precautions regarding medication or student's condition: (please include specific instructions for PRN, or as needed medications **)

I, _____, the Parent or Guardian of the above student, and have lawful custody of said child. I hereby give consent to appropriate district personnel to administer or assist in administering, or allow my child to self-administer, medication and/or treatment as specified by Dr._____, named above. I hereby give consent to the district to receive from or send to Dr._____ any information concerning my child's medical condition.

Signed by Parent or Gaurdian_____, _____*(date)*

I am a PHYSICIAN actively licensed by the State of California and I authorize the above specified medication/treatment.

_____ M.D., _____*(date)*

_____ Student _____*(date)*

PLEASE NOTE: It is the parents'/guardians' responsibility to see that this form is updated on a yearly basis or more often as needed should a child's medication, dosage, frequency of administration, or reason for administration change***. Return form to the District Health Specialist Lisa Callaghan lcallaghan@tamdistrict.org or fax to 415-945-1014.

*Parents/guardians shall provide medications in properly labeled, original containers along with the physician's instructions. For prescribed medication, the container also shall bear the name and telephone number of the pharmacy, the student's identification, and the name and phone number of the physician. Medications that are not in their original container shall not be accepted or administered.

**For medication that is to be administered on an as-needed basis, include the specific symptoms that would necessitate administration of the medication, allowable frequency for administration, and indications for referral for medical evaluation.
***At the beginning of each school year, the Superintendent or designee shall notify parents/guardians of the options available to students who need to take prescribed medication during the school day and the rights and/or responsibilities of parents/guardians regarding those options.

The Medications shall be delivered to the school by parents/guardians, unless the Superintendent or designee authorizes another method of delivery. However, we believe that this authoritarian by the Parent/Guardian to self-administer falls under "another method of delivery" so Parent/Guardian is not required to deliver the mediation to the school.

Authorization for Self- Administration of Medication

Is the student authorized to self-administer one or all of these medications while at school?

Yes_☐_ No_☐_

If yes, please complete the contract below.

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CONTRACT FOR SELF- ADMINISTERING MEDICATION AT SCHOOL

_____(*student's name*) has been instructed in the proper dosage and administration of

_____*(medication(s))*

We _____*(Name of Parent or Guardian)* and _____

(Name of physician) request that _____*(Name of student)* be permitted to carry their medication on their person and self -administer it as directed by our physician, and in compliance with District policy and procedures. In addition, I _____*(Name of Parent or Guardian)* release the school district and school personnel from civil liability if my self-administering Student suffers an adverse reaction as a result of self-administering medication pursuant to this paragraph.

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