School Medication Permission Form

Any pupil who is required to take, during the regular school day, prescription or non-prescription medication, may be assisted by the school nurse, an unlicensed personnel or other designated trained school personnel. A written statement shall be provided at least annually, and more frequently if there is a change in the pupil's health care provider (HCP), or if the medication, dosage, frequency or method of or reason for administration changes.

Please complete ONE form for each separate medication administered to the pupil.

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To be completed by Health Care Provider (HCP)

Student's name: _____ DOB: _____ School year: _____ - _____

Medication name: _____ Dosage: _____ Method of Administration: _____

Time/Frequency/Duration to be given: _____

If "as needed" medication, for what symptoms: _____

Possible side effects of medication: _____

For self-administration of inhaled asthma medication or Epinephrine only *(CEC 49414.5, 49423, 49423.1; 5 CCR 602):*

This is to verify that the above-named student must carry this emergency medication on his/her person. This student has been instructed in the proper administration of this medication, understands the appropriate dosage and possible side effects and is competent to safely self-administer this medication.

Self-carry inhaler: ____Yes ____No *Self-carry Epinephrine: ____ Yes ____No*

Health care provider signature: _____ Name: _____

Address: _____ Phone number: _____

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READ AND SIGN THE BACK OF THIS FORM
(OVER)

To be completed by parent / guardian (please read and sign)

I wish, and hereby give consent for a school nurse, an unlicensed personnel or other designated trained school personnel, to assist the pupil in administering the above medication to my child per the instructions of the above HCP. I release and hereby give my consent for the school nurse or other designated trained school personnel to communicate directly with the HCP and pharmacist, as may be necessary, regarding the HCP's written statement or any other questions that may arise with regard to the medication. I understand the right to terminate the consent for the administration of the medication at any time by notification in writing. I understand and agree to the following responsibilities regarding medication administration:

1. Prescription or ordered medication must be in a container labeled by the pharmacist or HCP, and 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 authorized health care provider.
2. Non-prescription medication must be in the original container with the label intact
3. An adult must bring the medication to the school and pick up any outdated or unused medication
4. If the medication is controlled (*i.e.*, Ritalin), a log must be provided and maintained tracking each use and administration of that medication.
5. Parents/guardians will provide all necessary supplies and equipment (e.g. measuring spoon, pill crusher) for medication administration
6. Parents/guardians will notify the school nurse or administrator and provide new consent for any changes to the above authorization

For self-administration of inhaled asthma medication or Epinephrine only (CEC 49423, 49423.1):
I, as the parent or guardian of the above named student, provide consent for the student to self-carry and self-administer the above named medication, as authorized by the HCP.
I will hold harmless and release the district and school personnel from civil liability if the student suffers an adverse reaction as a result of self-administering the medication

Parent / Guardian Signature: _____ Date: _____

Please see District Board Policy 5141.21 and Administrative Regulation 5141.21 ("Administering Medication And Monitoring Health Conditions") for a full listing of the District's and parents' rights and responsibilities.