

LODI UNIFIED SCHOOL DISTRICT  
Special Services/ Health Division



**Consent for Medication Administration/Self-Administration of Medication in School  
Release of Medical Information and Release of Liability**

School Site: \_\_\_\_\_

Teacher: \_\_\_\_\_

Student's Name: \_\_\_\_\_  
Last Name First Name MI

Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medication may be safely taken at school with the assistance of school staff if the following information is completed and the parent/guardian agrees to the following terms and condition: Note this form is valid for one year. (Ed Code 49423)**

1. Any pupil who is to take medication prescribed by a physician may be assisted by a school nurse or other designated school personnel. This accommodation is provided only when the schedule of medication would otherwise require the pupil to remain home, when medication is needed for emergency situations, or for specific health reasons. As a Parent/Guardian, I have the right to come to school and administer medication to my child if I feel it is necessary. Students may carry and self-administer medication (inhaler or Epi-pen) at school when the Parent/Guardian, physician, and school nurse determine student is competent to do so.
2. Parent/Guardian is required to bring the medication to school and to pick up any unused medication at the end of the school year.
3. Medication administered at school must be provided in its pharmacy-labeled bottle or in original pharmacy labeled injectable medication kit. The label shall state: student's name, date, name of medication, dosage, time(s) to be given, special instructions and physician's name. Parent/Guardian must provide appropriate dosage measuring device, especially for liquid medication. Over-the-counter medication must remain in manufacturer's container and be marked with student's name.
4. I acknowledge that I have an obligation to report to Lodi Unified School District and to execute a new consent form if student's medication, dosage, frequency of administration, or reason for administration changes during the school year.
5. The school is not legally obligated to provide this service and cannot be held responsible for missed or refused doses, side effects caused by the medication or any other problems. In return for the school district's assistance in administering the medication, I hereby waive any claim for injury against the school district, or its employees, arising from the administration of medication.
6. I further consent to the disclosure of my individually identifiable health information by physician to a school nurse or other personnel designated by Lodi Unified School District for the purpose of consulting with Physician regarding any questions that may arise with regard to the medication.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to hold harmless, release, and covenant not to sue the Lodi Unified School District, its officers, employees, and agents, for any and all liability, claim, or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self administration of medication.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Carry and Self-Administered Medication Only:**

I also hereby consent to allow \_\_\_\_\_ (student) to carry and self-administer the following medication during the regular school day or while at school-related activities: \_\_\_\_ auto-injectable epinephrine \_\_\_\_ inhaled asthma medication.

A written statement from the student's physician is noted below.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**To Be Completed by Physician**

**Please Print**

Name of Medication (as prescribed): \_\_\_\_\_ Dosage: \_\_\_\_\_

Method of Administration: \_\_\_\_\_ Time(s) to be dispensed at school: \_\_\_\_\_

Duration: \_\_\_\_\_ Health condition for medication: \_\_\_\_\_

Special Instructions/Precautions: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Pursuant to Education Code sections 49423 and/or 49423.1, this is to confirm that \_\_\_\_\_ (student) is able to carry and self-administer the following medications: \_\_\_\_ auto-injectable epinephrine \_\_\_\_ inhaled asthma medication

A new consent form will be required if student's medication, dosage frequency of administration, or reason for administration changes during the school year. The current authorization will be effective for one year.

I, \_\_\_\_\_ certify that the foregoing is true and correct.  
Physician's Name (print)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Fax: \_\_\_\_\_

Address/City \_\_\_\_\_ Telephone: \_\_\_\_\_

**Estimados Padres ó Tutor:**

La medicina puede ser dada en la escuela solamente si el padre ó el doctor llenan la información al reverso de esta forma. La medicina debe ser traída a la escuela por el padre y ser rotulada por el farmacéutico. El distrito escolar no es responsable por los resultados ó efectos secundarios de la medicina. Con su firma usted está de acuerdo en "renunciar por mi parte y por parte de mi hijo(a) al derecho de sostener cualquier acción legal por daños contra el distrito escolar por cualquier efecto negativo que la medicina pueda tener en mi hijo(a)".

**Spanish Version - Medication at School**

**Txog:** Cov ua niam ua txiv txhua tus

Hauv tsev kawmntawv yuav muab tshuaj rau koj tus menyuam noj tau, tiam sis yuav tsum yog niam thiab txiv thiab tus kwstshuaj (parent and physician) sau teb rau daim ntawv nyob sab nraum no. Niam thiab txiv yuav tsum nqa cov tshuaj uas tus menyuam yuav noj ntawd tuaj rau hauv tsev kawmntawv thiab cov tshuaj ntawd yuav tsum muaj daim ntawv sau qhia kev noj tshuaj los ntawm lub tsev muag tshuaj noj ntawd kom zoo. Nco nisoov tias yog muaj teebmeem li cas los ntawm txoj kev noj tshuaj ntawd mas lub tsev kawmntawv yuav tsis ris lub txim ntawd. Koj yuav tau sau npe lees paub tias, "Ntawm koj tus kheej thiab koj tus menyuam yuav tsis sau ntab ntawv foj lub tsev kawmntawv rau tej yam uas lawv muab tshuaj rau koj tus menyuam noj es ho ua rau nws muaj mob".

**Hmong Version**

**Phụ huynh/Người báo hộ thân mến:**

Thuốc có thể cho uống tại trường với điều kiện là phụ huynh và bác sĩ phải điền vào phần sau của thu này. Phụ huynh phải mang thuốc vào trường và phải có nhân hiệ do được sĩ ghi rõ cách dùng. Nhà trường không chịu trách nhiệm về kết quả của thu uống hoặc các triệu chứng có thể xảy ra trong khi sử dụng thuốc. Chữ ký phụ huynh đồng ý là "Với nhân danh là cha mẹ và nhân danh của con em tôi, tôi từ bỏ tất cả quyền lợi luật pháp về thua kiện lại nhà trường về sự thiệt hại ảnh hưởng đến con em tôi trong khi chúng sử dụng thuốc tại trường".

**Vietnamese Version**

**សូមជំរាបមកដល់គាថិការណ៍ព្យាបាល:**

ផ្គត់ផ្គង់ព្យាបាលឱសថសាណាម្យ៉ាងបាន ពេលវេលាណាមួយ និងវេជ្ជបណ្ឌិតបញ្ជាក់មាននៅលើឆ្នុងក្រដាស នេះ ។ មាតិកាផ្គត់ផ្គង់ព្យាបាលត្រូវយកមកស្រាវជ្រាវ ហើយត្រូវមានការសម្រេចចិត្តពីគ្រូបង្ហាត់ ។ ក្នុងសិក្សាមិនមានទុកសម្រាប់សិស្សដែលរក្សាទុក ឬ មានការអនុវត្តលើ មូលហេតុដោយ សារមកពីផ្គត់ផ្គង់ ។ ខ្ញុំ: ហត្ថលេខាយល់ស្របពេលវេលា ខ្ញុំចូល និងត្រូវយល់ និងមានសិទ្ធិបដិសេធន មិនប្រកាន់ ឬ ផ្គត់ផ្គង់សិក្សា ព្រោះតែផ្គត់ផ្គង់ព្យាបាលលើ ផ្ទៃក្នុងមានការខុសគ្នា ឬ ផ្ទៃក្នុងខ្ញុំ មានផ្លូវមិនល្អ ។ "

Khmer/Cambodian Version

**Hmong Version**

**محترم والدین/سرپرست :**

مکتول میں طلباء کو اسی صورت میں دوائی دی جاسکتی ہے جبکہ ڈاکٹر اور والدین اس فارم کے پچھلے حصے کو مکمل کریں۔ دوائی والدین سکول میں خود لے کر آئیں اور اس پر فارمیسی کا لیبل لگا ہو۔ ضلعہ سکول دوائی کے نتائج اور رد عمل کا نمہ دار نہیں ہو گا۔ آپ کو دستخط کرنا ہونگے کہ میں اپنے اور بچے کی جانب سے دوائی کے ردعمل اور برے نتائج کے سلسلے میں سکول کو ذمہ دار ٹھہرانے کے حق سے دست بردار ہوتا/ہوتی ہوں۔