Romoland School District

AUTHORIZATION FOR PRESCRIBED AND OVER THE COUNTER MEDICATION ADMINISTRATION AT SCHOOLS WITHIN THE COUNTY OF RIVERSIDE

Name of Student	Date of Birth	Grade	School

Education code 49423 authorizes that any pupil who is required to take, during the regular school day medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and the time schedules by which such medication is to be taken and (2) a written statement from the parent/guardian of the pupil indicating the desire that the school district assist the purple in the matter set forth in the physician's statement.

I request medication prescribed, be administered to my student and agree to hold the Romoland School District, its officers or employees harmless from all liability or claims which might arise out of the arrangements. I give my permission for the District Nurse to contact the physician for consultation as needed. I understand that all medication will be destroyed at the end of the school year unless other arrangements are made and it is picked up by a parent or designee.

_____	_____	_____	_____
Parent/Guardian Signature.	Home Phone.	Work phone.	Date

Name of Medicine	Heath Condition for which medicine RX
Time(s) to be taken (Daily):	Dosage
If as needed (PRN) Frequency: _____Every 3 to 4 hours. _____Every 4 to 6 hours	Method of Administration
Precaution-Possible untoward reactions	Name of Physician(please print)
Date to be discontinued	Physician's Telephone Number
Date	Physician's Signature

Please return this form to your child's school health office signed by the physician and the parents or guardian. **NO MEDICATION WILL BE ADMINISTERED WITHOUT THESE REQUIRED SIGNATURE**

ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

A. **GENERAL POLICY**

1. No student shall be given medication during school hours except upon a written request from a licensed physician/healthcare provider who has the responsibility for the medical management of the student. All such requests MUST be signed by the parent or guardian.
2. A new form is required for each prescription change and at the beginning of each school year.

B. **RESPONSIBILITY OF THE PARENT OR GUARDIAN**

1. Parents/guardians are encouraged to cooperate with the physician to develop a schedule so the necessity for taking medications at school will be minimized or eliminated.
2. Parents/guardians will assume full responsibility for the supply and transportation of all medications.
3. Parents/guardians may administer medication to their child on a scheduled basis arranged with the school. Students ARE NOT PERMITTED to carry prescribed or over-the-counter medication on a school campus.
4. Parents/guardians MUST pick up unused medications from the school office during and at the close of the school year.

MEDICATIONS REMAINING AFTER THE LAST SCHOOL DAY WILL BE DISCARDED.

C. RESPONSIBILITY OF THE PHYSICIAN AND PARENT OR GUARDIAN

1. A request form for prescribed medication must be completed by the pupil's physician, signed by the parent or guardian, and filed with the school administrator or his designated representative.
2. The container MUST be clearly labeled by the physician or pharmacy with the following information:
    a. Student's name
    b. Physician's name
    c. Name of Medication
    d. Dosage, schedule (specific to school) and dose form
    e. Date of expiration of prescription

D. RESPONSIBILITY OF SCHOOL PERSONNEL

1. School administrators will assume responsibility for securing medications in a locked container.
2. Students will be ASSISTED in taking medications according the physician's instructions and the procedure observed by a school staff member.