



# Administration of Medication Form

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

## PARENT/GUARDIAN RESPONSIBILITIES AND STATEMENT

I, as a parent or legal guardian of the above listed student, request and understand the following in accordance with California Education Code sections 49423-49423.5 and the Department of Education in order for the student to take medication during school hours, school activities and field trips:

- My student will not be assisted with medication at school until all requirements are met.
- I shall provide a new written authorized health care provider's statement with any changes in medication, dose, medical provider, time or discontinuation of medication.
- I understand that a school nurse is not on campus daily. During his/her absence, a designated unlicensed trained school staff employee will administer or otherwise assist my student in the administration of below prescribed or over the counter medication.
- Medication will be taken on all school activities and field trips during school hours unless otherwise directed.
- All medication must be brought to the school by a parent/guardian in the original container, with a pharmacy label if applicable.
- If agreed on by the students health care provider, I consent to allow my child to carry and self-administer the below medication and release the district and school personnel from civil liability if my student suffers an adverse reaction as a result of self-administering the medication.
- This request for medication administration can be terminated at any time or for otherwise assisting the student in the administration of medication at any time.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

## HEALTH CARE PROVIDER STATEMENT (To be completed by health care provider)

The child named above is under my care for the following medical diagnosis: \_\_\_\_\_

Medication	Dose	Route	Time or Frequency	Duration
<input type="checkbox"/> Scheduled <input type="checkbox"/> PRN				
<input type="checkbox"/> Scheduled <input type="checkbox"/> PRN				

For PRN medication: Symptoms that would necessitate administration: \_\_\_\_\_

Indications for referral for medical evaluation: \_\_\_\_\_

Precautions or side effects: \_\_\_\_\_

- I confirm that it is medically necessary for the student to carry this medication on campus, and indicate one of the following:
- Designated school personnel to administer to student
  - Student has been trained by healthcare provider to self-administer

Health Care Provider name/address/phone:

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

PARENT/GUARDIAN

HEALTH CARE PROVIDER



# Administración del Formulario de Medicamentos

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

## DECLARACION Y RESPONSABILIDADES DE LOS PADRES/TUTORES

Yo, como padre o tutor legal del estudiante enumerado arriba, solicito y entiendo lo siguiente, según el Código de Educación de California secciones 49423-49423.5 y el Departamento de Educación en orden para que el estudiante tome medicamento durante las horas escolares, actividades escolares y viajes de campo:

- Mi estudiante no será asistido con medicamentos en la escuela hasta que todos los requisitos sean cumplidos.
- Debo proporcionar un nuevo escrito declaración autorizada del médico con los cambios en la medicación, dosis, proveedor medico, tiempo, o discontinuación de la medicación.
- Entiendo que una enfermera de la escuela no está en la escuela diariamente. Durante sus ausencia, un empleado de personal entrenado sin licencia designado de la escuela administrara o, a lo contrario, asistirá a mi estudiante en la administración de abajo prescrita o sobre los medicamentos sin receta.
- La medicación se tomara en todas las actividades escolares y excursiones durante el horario escolar a menos que se indique lo contrario.
- Todos los medicamentos se deben traer a la escuela por un padre o tutor en el envase original, con una etiqueta de la farmacia si es aplicable.
- Si acordado por el proveedor de cuidado de salud, doy mi consentimiento para permitir que mi hijo lleve y auto administre el medicamento, enumerado abajo, y libero de responsabilidad civil el distrito y el personal de la escuela, si mi estudiante sufre una reacción adversa como consecuencia de la auto-administración de la medicación.
- Esta solicitud de administración de medicamentos puede ser terminada en cualquier momento o de lo contrario asistir al estudiante en la administración de la medicación en cualquier momento.

\_\_\_\_\_  
Firma del padre/tutor

\_\_\_\_\_  
Nombre en Letras de Imprenta

\_\_\_\_\_  
Fecha

## HEALTH CARE PROVIDER STATEMENT (To be completed by health care provider)

The child named above is under my care for the following medical diagnosis: \_\_\_\_\_

<u>Medication</u>	<u>Dose</u>	<u>Route</u>	<u>Time or Frequency</u>	<u>Duration</u>
<input type="checkbox"/> Scheduled <input type="checkbox"/> PRN				
<input type="checkbox"/> Scheduled <input type="checkbox"/> PRN				

For PRN medication: Symptoms that would necessitate administration: \_\_\_\_\_

Indications for referral for medical evaluation: \_\_\_\_\_

Precautions or side effects: \_\_\_\_\_

- I confirm that it is medically necessary for the student to carry this medication on campus, and indicate one of the following:**
- Designated school personnel to administer to student
  - Student has been trained by healthcare provider to self-administer

Health Care Provider name/address/phone:

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

PADRE/TUTOR LEGAL

HEALTH CARE PROVIDER