CORCORAN UNIFIED SCHOOL DISTRICT HEALTH SERVICES
RECREATION ASSOCIATION OF CORCORAN
IN SCHOOL MEDICATION FORM
For Prescription and Over-the-Counter Medications Authorized by Physician

NAME OF STUDENT:_____ **DOB:** _____ **PHONE:**_____

STUDENT ID#_____ **SCHOOL:**_____ **GRADE/ROOM:**_____

California Education Code section 49423 permits a school nurse or other designated school personnel to assist any pupil who must take medication prescribed by his/her physician and surgeon during the regular school day if the District is provided:

1. An order in writing from the physician and surgeon or physician assistant detailing the name of the medication and giving instructions for the method, amount, and time schedules by which the medication is to be taken, and
2. A request in writing signed by the parent or guardian indicating the desire that the school district assist the student in the matters set forth in the statement of the physician and surgeon or physician assistant.

No medications can be given without a physician's signature. **An In-School Medication Form must be completed each school year for all prescription and over-the-counter medications. This form is only valid for the current school year.**

TO BE COMPLETED BY STUDENT'S HEALTHCARE PROVIDER:

Medication is necessary at school for the following reason: _____

Name of Medication/Dosage (mg, units, etc. – tabs, puffs): _____

Time Schedule/Frequency/Duration/Route_____

Precautions, possible reactions and interventions: _____

If medication is administered as needed:

Symptoms requiring medication administration: _____

Frequency (if different from above):_____

Medical Evaluation Referral Necessary When:_____

Medication to be kept on person? Yes ☐ No ☐ Prescription date:_____

Instructions and/or precautions: _____

Healthcare Provider Signature:_____Provider NPI#:_____Date:_____

Healthcare Provider Address:_____ Phone:_____

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PARENT PERMISSION: I understand and request the school nurse or designated school personnel/staff assist my student with medication administration under the conditions set forth in the healthcare provider statement. I give consent for the school nurse to directly communicate with my child's physician or licensed healthcare provider and school personnel as needed with regard to this medication and health condition. I understand my responsibility to enable the school nurse to administer or otherwise assist with the administration of medication pursuant to the healthcare provider statement, including providing a written statement from my student's authorized healthcare provider, delivering my student's medication to appropriate District/RAC staff in a properly labeled and authorized container, and providing all necessary supplies and equipment for the administration of my student's medication. I understand that I may terminate consent for the administration of the medication or assistance of medication administration for my child at any time. I also understand that I must provide a new authorized healthcare provider statement if my child's medication, dosage, frequency of administration, or reason for administration changes.

PARENT/ GUARDIAN SIGNATURE:_____ **DATE**_____

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ALL MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION CONTAINER FROM THE PHARMACY

_____ _____

Health Clerk/LVN **Date** **School Nurse** **Date**