CABRILLO UNIFIED SCHOOL DISTRICT
498 Kelly Ave, Half Moon Bay, CA 94019 • 650 712-7100 • Fax 650 726-0279 • www.cabrillo.k12.ca.us

AUTHORIZATION AND RELEASE
FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

☐**To be completed by the parent/guardian prior to full completion by the licensed physician.**

Student's Name _____ Date of Birth _____ Grade _____

School _____ Teacher/Counselor (If Applicable) _____

Parent/Legal Guardian Name _____

WHENEVER POSSIBLE, MEDICATION SHOULD BE GIVEN AT HOME, BEFORE AND AFTER SCHOOL, PROVIDING THIS MEETS WITH THE PHYSICIAN'S APPROVAL.

☐**To be completed by the physician or other healthcare provided licensed by the State of California to prescribe medication.**

Self administration at school for the following medications only:

☐ Inhaler ☐ Epinephrine ☐ Glucagon ☐ Insulin ☐ Other (diabetes related) _____

_____ (Provider Initial) **The above named student is under my care and needs to carry this medication with him/her while at school. I agree that the child is capable of self- administration and is able to manage this medication responsibly.**

1. Diagnosis for which the medication is prescribed _____

   Medication: _____ Dosage: _____

   Time _____ Route/Method _____

   Possible side effects: _____

   Estimated termination date: _____

   If dosage is as needed (PRN), the symptoms that necessitate administration and allowable frequency:

   _____

2. Diagnosis for which the medication is prescribed _____

   Medication: _____ Dosage: _____

   Time _____ Route/Method _____

   Possible side effects: _____

   Estimated termination date: _____

   If dosage is as needed (PRN), the symptoms that necessitate administration and allowable frequency:

   _____

The student is under my care and requires that the above medication be taken during school hours.

Physician's Name _____ License No. _____

Office Address _____

Phone Number _____

Fax Number _____

Physician's Signature _____

Date _____

Physician/Clinic's stamp

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☐Parent/Guardian Agreement (continuation)

Education Code 49423: Notwithstanding the provisions of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

"Medication" includes prescription medication, over-the-counter- medication, nutritional supplements and herbal remedies. Parents are responsible for providing all medication and supplies and equipment necessary to administer the medication. No medications, including over-the-counter medications, will be given without a prescription. The medication prescription must be current and medication must be supplied in the original package or original prescription bottle with pharmacy label attached (ask your pharmacist to divide the medication into two bottles completely labeled: one for home and one for school). The medication must be prescribed to the student to whom it will be administered and all medication containers must include a label with the student's name, physician's name, the name of the medication, and directions for use.

- **I authorize and hereby give permission and request that designated school personnel assist my child in taking this prescribed medication (including prescribed over-the-counter medication, nutritional supplements and herbal remedies) as prescribed by my child's health care provider. The medication may be administered by trained, non-medical school employees, under the supervision of the District Nurse. The school nurse may not be present during the administration of the medication.**
- **I agree to, and do hereby release and hold the District and its employees and contractors harmless from any and all claims, demands, causes of action, liability or loss of any type, because of or arising from acts or omissions with respect to this medication and agree to indemnify each of them with regard to any judgment or claim rendered against them arising out of this medication administration arrangement. I understand that my child may not have or take medication at school unless all requirements are met.**
- **I hereby give consent for a school nurse to communicate with my child's health care provider and counsel school personnel as needed with regard to this medication.**

Student's Name _____ Date of Birth _____ Gender: M ☐ F ☐

I have read and understood the above authorization and release. I will immediately notify the school if there is any change in medication my child is taking at school. I understand that this authorization is in effect for a maximum of one school year, and the District will require a new authorization at the beginning of each school year, or if any changes in prescription occur.

Signature of Parent/Legal Guardian _____ Date _____

Home Telephone _____ Work Telephone _____

Cell Telephone _____ Email _____

☐For School Office Use Only

Authorization for Medication Administration received by _____ On (date) _____