

St. Michael's Episcopal Day School
(916) 485-3418
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PRESCRIPTION & EMERGENCY MEDICATION IN SCHOOL FORM
2025-2026 School Year

Student Name: _____ Birthdate: _____ Grade: _____

Parent/Guardian Name(s): _____

Phone Number(s): _____

I. Administrative Statement

Medication may be administered to students by school personnel when a physician deems it necessary for the medication to be taken during school hours. While school staff will cooperate with parents by providing a secure location for medication storage, the primary responsibility for ensuring the child takes the medication rests with the student and the child's parent(s)/guardian(s).

II. Consent & Acknowledgment

I understand and acknowledge the following:

- A **physician's signature** is required for all medications—no exceptions. **No medications** will be administered without a physician's approval on file.
- All prescription medications must be provided in their original pharmacy-labeled containers.
- All medications will be administered according to the label instructions or as directed by a licensed healthcare provider.
- I am required to personally deliver the medication to the school and retrieve it at the end of the school year. Medication may not be sent with my child.
- The school nurse may not always be available to administer this medication; another designated staff member may be assigned to do so.
- The school and its employees are not responsible for any adverse reactions that may occur from medication administration, including any resulting legal or civil action.
- The school nurse or other designated school personnel can consult with the prescribing health care provider and/or pharmacist regarding the medication.
- I will inform the school nurse of any changes to my child's medical condition or medication regimen and will provide updated consent forms as necessary.
- It is my child's responsibility to request medication when needed.

*An additional form must be completed for food allergies/anaphylaxis care plan.

Parent/Guardian Signature: _____ Date: _____

III. Physician Medication Instructions

Diagnosis: _____

Medication: _____

Dosage: _____ Method of Administration: _____

Time to be taken: _____

Indication for medication: _____

Length of time to be taken: _____

Special instructions/precautions: _____

Possible side effects: _____

IV. Physician Authorization

My signature below provides the authorization for the above written orders to be implemented by the school nurse or other designated school personnel. This authorization is for a maximum of one (1) year.

A. Physician Permission to Carry & Self-Administer EMERGENCY Medication

Students are only permitted to carry their medications that are for *life-threatening conditions*, such as severe allergic reactions needing an EpiPen, asthma inhalers, and insulin/glucagon for diabetes.

- It is this authorized health care provider's opinion that the student is competent to safely carry and self-administer their emergency medication if needed.
- It is this authorized health care provider's opinion that the student should NOT carry and self-administer their emergency medication.

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

V. Parent/Guardian Permission to Carry & Self-Administer EMERGENCY Medication

Students are only permitted to carry their medications that are for *life-threatening conditions*, such as severe allergic reactions needing an EpiPen, asthma inhalers, and insulin/glucagon for diabetes.

- In agreement with my child's physician, I give permission for my child to carry and to self-administer the above emergency medication.

Parent/Guardian Signature: _____ Date: _____