



Lodi Unified School District
Health Services Department
1305 E. Vine Street, Lodi, California 95240
Lodi (209) 331-7080, Fax (209) 331-7084

CONSENT FOR MEDICATION ADMINISTRATION/SELF-ADMINISTRATION OF MEDICATION IN SCHOOL/ RELEASE OF MEDICAL INFORMATION AND RELEASE OF LIABILITY

Name of Student: _____ Date of Birth: _____

School Site: _____ Grade: _____ Teacher: _____

Medication may be safely taken at school with the assistance of school staff if the following information is completed and the parent/guardian agrees to the following terms and conditions. NOTE: THIS FORM IS VALID FOR ONE CALENDAR YEAR. (Ed Code 49423)

1. Any pupil who is to take medication prescribed by a physician may be assisted by the school nurse or other designated school personnel. This accommodation is provided only when the schedule of medication would otherwise require the pupil to remain home, when medication is needed for emergency situations, or for specific health reasons. As the parent/guardian, I have the right to come to school and administer medication to my child if I feel it is necessary. Students may carry and self-administer medication (auto-injectable epinephrine, inhaled asthma medication, or other medication approved by the school nurse) at school when the parent/guardian, physician, and school nurse determine student is competent to do so.
2. Parent/Guardian is required to bring the medication to school and to pick up any unused medication at the end of the school year.
3. Medication administered at school must be provided in its pharmacy-labeled container or in original pharmacy labeled injectable medication kit. The label shall state student's name, date, name of medication, dosage, time(s) to be given, special instructions, and physician's name. Parent/Guardian must provide appropriate dosage measuring device, especially for liquid medication. Over-the-counter medication must remain in manufacturer's container and be marked with student's name.
4. As the parent/guardian, I acknowledge that I have an obligation to report to Lodi Unified School District and execute a new consent form if student's medication, dosage, frequency of administration, or reason for administration changes during the school year.
5. As the parent/guardian, I further consent to the disclosure of my student's individually identifiable health information by physician to a school nurse or other personnel designated by Lodi Unified School District for the purpose of consulting with physician regarding any questions that may arise with regard to the medication and its administration.

TO BE COMPLETED BY PARENT/GUARDIAN (check appropriate carry/self-administer option, then sign where noted)

****I hereby consent to allow my child to carry and/or self-administer this medication during the regular school day and/or while at school-related activities, as per the Physician's orders noted below****

_____ NO _____ YES (must be approved by Physician and Credentialed School Nurse)

I, on behalf of myself, my child, our heirs, executors, and assignees, hereby agree to hold harmless, release, and covenant not to sue the Lodi Unified School District, its officers, employees, and agents, for any and all liability, claim, or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from administration of this medication for my student. I agree to all terms, conditions, and physician's orders as stated on this form.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Address: _____ Phone Number: _____

TO BE COMPLETED BY PHYSICIAN (please print when completing, then sign where noted)

Name of Medication: _____ Dosage: _____

Method of Administration: _____ Time(s) to be Dispensed at School: _____

Duration: _____ Health Condition for Medication: _____

Special Instructions/Precautions: _____

Possible Side Effects: _____

****Pursuant to Education Code Sections 49423 and/or 49423.1, this is to confirm that student is able to carry and/or self-administer this medication**** _____ NO _____ YES (must be approved by Parent and Credentialed School Nurse)

A new consent form will be required if the student's medication, dosage, frequency of administration, or reason for administration changes during the school year. The current authorization will be effective for one calendar year.

I, _____ (Printed Name of Physician) certify that the foregoing is true and correct.

PHYSICIAN'S SIGNATURE: _____ DATE: _____ NPI# _____

Address: _____ Telephone: _____

****Credentialed School Nurse: It is my professional opinion that student is competent to safely carry and/or use this medication by themselves, as per above Physician orders and Parent authorization**** _____ No _____ Yes _____ N/A

Credentialed School Nurse Signature (confirming review of form): _____ Date: _____