SERVITE HIGH SCHOOL

PARENT NOTIFICATION FOR THE ADMINISTRATION OF PRESCRIPTION MEDICINE AT SCHOOL

To The Parent/Guardian:

Medical treatment is the responsibility of the parent(s) and family Health Care Provider Medications, both prescription and over the counter, are rarely given at school; the only exceptions involve special serious problems where it is deemed absolutely necessary by the Health Care Provider that the medication is given during school hours. The parent is urged, with the help of your child's Health Care Provider, to work out a schedule of giving medication at home, outside school hours whenever possible.

California Educational Code, Section 49423 allows school personnel to assist in carrying out Health Care Provider recommendations. Designated non-medical school personnel may be administering your child's medication. Medication will be sealed, stored and locked or refrigerated if required. Medication must be signed into the Health Room and signed out at the end of the school year.

Students may carry emergency medicine such as EpiPen or inhalers **(only if authorized by Health Care Provider, parent and school administration)**. A second EpiPen or inhaler must be kept at school for emergency use. We recommend that any student who has a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of his prescription medication at school with the appropriate consent forms in case of disaster.

If medication is to be administered at school, all of the following conditions must be met:

1. A written statement signed by the Health Care Provider specifying the condition for which the medication is to be given, the name, dosage, time, route, and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school with the Request for Medication form.
4. Medication must be in your son's original, labeled pharmacy container.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. A separate form is required for each medication.

NOTE: Please discuss your Health Care Provider's instructions with your son, so that he is aware of the time medication is due at school.

This request is valid for a maximum of one year. **Whenever there is a change in medication**, dose, time, or route, the parent(s) and Health Care Provider must **complete a new form**.

PRESCRIPTION MEDICATIONS 2026-2027

Student's Last Name: _____First Name: _____Birthdate: _____

Address: _____City: _____Zip Code: _____

Parent request for the administration of prescription medications:
California Education Code Section 49423 allows designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school, maintain, or improve his potential for education and learning.

I request that medication be administered to my son _____, in accordance with our Health Care Provider's written instructions, I understand that designated school personnel will administer medication. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing Health Care Provider and give permission to contact the Health Care Provider when necessary. I give permission for the school nurse to exchange medication-related information with the authorized Health Care Provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Parent/Guardian Signature: _____Date: _____

Work Phone: _____Home Phone: _____Mobile: _____

HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION: (Submit one form per medication)

Diagnosis/Reason for Medication:_____
Medication: _____Dose: _____Route: _____Time: _____

Possible reactions: (possible serious reactions with these medications, i.e. allergic reactions, Localized/general, etc.): _____

Instructions for emergency care: _____

The above medication cannot be scheduled for any time other than during school hours. Non-medical school personnel may administer this medication.

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (Print Clearly): _____

Phone Number: _____Provider NPI#: _____

Date of request: _____Date to discontinue medication: _____

This student is permitted to carry/self-administer their emergency Inhaler/EpiPen. This student has been instructed in and demonstrates an understanding of proper usage.

Health Care Providers Initials _____

OFFICE STAMP