NAME: _____
TEACHER/GRADE: _____
SCHOOL: _____

PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

TO BE COMPLETED BY PHYSICIAN OR OTHER HEALTHCARE PROVIDER LICENSED BY THE STATE OF CALIFORNIA TO PRESCRIBE MEDICATION.

STUDENT NAME (PRINT): _____

DIAGNOSIS FOR WHICH THE MEDICATION IS PRESCRIBED: _____

DOSAGE: _____ TIME: _____ ROUTE: _____

IF DOSAGE IS AS NEEDED (PRN), THE SYMPTOMS THAT NECESSITATE ADMINISTRATION AND ALLOWABLE FREQUENCY: _____

_____

ESTIMATED TERMINIATION DATE: _____

POSSIBLE SIDE EFFECTS: _____

The child named above is under my care. It is necessary for him or her to receive the above-prescribed medication during school hours. The medication may be administered by trained, nonmedical school employees.

DATE: _____ PHYSICIAN: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

PHYSICIAN SIGNATURE: _____
(Physician/Clinic Stamp)

I hereby give permission for school personnel to administer medication to my child during the school day as prescribed by the child's physician.

SIGNATURE OF PARENT/GUARDIAN: _____DATE: _____

PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

California Education Code Section 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day, provided that appropriate authorization is given.

"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 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. 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.

_____	**M F**	_____
Student's Name (Print)	**Sex**	**Date of Birth**

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 the each school year, or if any changes in prescription occur.

_____	_____
Date	Signature of Parent or Legal Guardian

Home Telephone: _____

Work Telephone: _____

Cell Telephone: _____