PARENT/PHYSICIAN RELEASE FOR MEDICATION IN SCHOOL

Please Note: This form must be completed each school year

POLICY GOVERNING THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL:

When it is necessary for students to take prescriptions or over the counter medication during school hours the following procedure shall be followed:

- Medication cannot be administered by school personnel unless there are completed parent and physician request forms on file in the school office.
- The medication must be sent to the school in the prescription bottle or original container.
- Medication cannot be kept on student's person without the written consent of parent and physician.

PARENT REQUEST: _____ _____ _____ _____ _____

Student's Last Name | Student's First Name | Date of Birth | Teacher's Name | Grade

In agreeing to have the school administer my child's medication, I voluntarily agree to release, discharge, and hold harmless Roseville City School District and its officers, agents and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which cause my child's illness, injury, death, and damages of any nature in any way connected with the administration of medication. As the parent of the above student, in the event there is no school nurse or other licensed person to administer medication, I give consent for a trained unlicensed assistive person/trained health care aid to administer the prescribed medication to the above student. I understand that I may terminate the consent for the administration of the medication or for otherwise assisting the student in the administration of medication at any time. ***I authorize the District to communicate with the physician below regarding my child's medical condition and/or medication prescribed for it.***

Parent/Guardian Signature: _____ Date: _____

Phone: _____ Additional Phone: _____

Additional Emergency Contact: _____ Phone: _____

PHYSICIAN'S REQUEST:

Medication Name: _____ Dose: _____

Frequency/time to be given at school: _____

Reason for Medication/Diagnosis: _____ Possible Side Effects: _____

Medication Name: _____ Dose: _____

Frequency/time to be given at school: _____

Reason for Medication/Diagnosis: _____ Possible Side Effects: _____

If medication is an inhaler, has student been instructed on correct use and may carry/self-administer metered dose inhalers? Yes No Physician's initials: _____

As the prescribing physician, in the event there is no school nurse or other licensed person to administer medication, I authorize a trained unlicensed assistive person/trained health care aid to administer this prescribed medication to the above student.

Physician's Signature: _____ **Date**: _____

PHYSICIAN'S NAME:
ADDRESS:
PHONE NUMBER:
FAX NUMBER:

PLEASE RETURN TO:
Chilton Middle School
4501 Bob Doyle Drive
Roseville, California 95747
Fax Number: (916) 771-1871

Nurse's Signature: _____ **Principal's Signature:** _____

BASIC LEGAL PROVISION: California Education Code 49423 (1976)

Notwithstanding the provision of Section 49423, any pupil who is required to take during the regular school day medication prescribed form him/her 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 methods, amount, and time schedules by which such medication is to be taken; and (2) a written statement form the parent or guardian of the pupil indicating the desire that the school district assist the pupil in matters set forth in the physician's statement.