

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.

Student's Last Name	PARENT REQUEST:					
Roseville City School District and its officers, agents and employees for any and all claims of liability arising out of their neglige ecklessness 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 cicensed person to administer medication, I give consent for a trained unlicensed assistive person/trained health care aide to administer the prescribed medication to the above student. I understand that I may terminate the consent for the administration of 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: Phone: Additional Emergency Contact: Phone: Additional Emergency Contact: Physician's REQUEST: Medication Name: Prequency/time to be given at school: Reason for Medication/Diagnosis: Possible Side Effects: Medication Name: Prequency/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-administ metered dose inhalers? Yes No Physician's initials: Physician's Signature: Date: Physician's Signature: Date: PHYSICIAN'S NAME: ADDRESS: PHYSICIAN'S NAME: ADDRESS: Bate PLEASE RETURN TO: Diamond Creek Elementary ADDRESS: Bate PleAse Return To: Diamond Creek Elementary ADDRESS: Bate I Alifornia 95747	Student's Last Name	Student's First Name	Date of Birth	Teacher's Name	Grade	
Phone:Additional Phone:	Roseville City School District and its officers, agreeklessness or any other act of omission which connected with the administration of medication icensed person to administer medication, I give administer the prescribed medication to the about the medication or for otherwise assisting the studies.	ents and employees for any a cause my child's illness, inju n. As the parent of the above e consent for a trained unlice ove student. I understand tha udent in the administration of	and all claims of li iry, death, and da student, in the ev nsed assistive pe t I may terminate medication at an	iability arising out of the mages of any nature of the mages of any nature of the mages of the consent for the act of time. I authorize the consent for the act of time.	heir negligenc in any way ol nurse or oth care aide to dministration o he District to	
Phone:Additional Phone:	Parent/Guardian Signature:			Date:		
PHYSICIAN'S REQUEST: Medication Name:	Phone:	Additional Phone	:			
PHYSICIAN'S REQUEST: Medication Name:	Additional Emergency Contact:		Phone			
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Frequency/time to be given at school: Reason for Medication/Diagnosis: Medication Name: Frequency/time to be given at school: Reason for Medication/Diagnosis: Possible Side Effects: Medication Name: Frequency/time to be given at school: Reason for Medication/Diagnosis: Possible Side Effects: Medication is an inhaler, has student been instructed on correct use and may carry/self-administ 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 author a trained unlicensed assistive person/trained health care aide to administer this prescribed medication to the above student. Physician's Signature: Physician's Signature: Date: PLEASE RETURN TO: Diamond Creek Elementary 3151 Hopscotch Way Roseville, California 95747	PHYSICIAN'S REQUEST:					
Medication Name:	Medication Name:		Dose:			
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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 for 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.