Fruitvale School District
7311 Rosedale Highway, Bakersfield, CA. 93308-5738
661-589-3830

Authorization to Assist in Administration of Medication

Physician's Statement

_____ is under my professional care and is on the following medication:

1. Physical condition for which mediation is to be given _____
   _____.
2. Name of medication _____.
3. Method of Administration: Tablets: _____ Inhaler: _____ Other: _____
4. Dose _____. Schedule of doses _____.
5. This medication is to be continued as above until: _____.
6. Precautions, possible reactions, and interventions: _____
   _____.
7. For ASTHMA only: Is child authorized to self-medicate: ___ Yes ___ No
   Does child need to carry medication at all times? ___ Yes ___ No
   If medicine is to be given "WHEN NEEDED" describe indications: _____
   _____

I recommend that school personnel assist in the administering of the prescribed medication during school hours.

_____ _____
Signature of Physician Date

_____ _____
Physican's Address Telephone #

PARENT or GUARDIAN STATEMENT

As the Parent(s) or Guardian(s) of the above named pupil, we request the Fruitvale School District to assist in carrying out the physician's instructions in the administering of the prescribed medication during the school day.

We agree to notify our child's teacher and the school office immediately of any change in the medication, dosage, and frequency recommended, and sign a new statement when any differences occur from the above directions.

We understand that the school is not legally obligated to administer medication to any child and therefore agree to hold the school district and its employees harmless from any and all liability for the results of such medication or the manner in which it is administered, and to indemnify the school district and its employees for any liability arising out of this agreement. We agree that any time our child is to have his prescription medicine at school, it will be in a container with the pharmacist's label attached describing the kind of medication, dosage, how often it should be taken, and the prescribing doctor's name.

_____ _____ ____ _____
Student's Name Birthdate Grade School

Date: _____ Parent/Guardian Signature: _____

PLEASE RETURN THIS FORM TO THE SCHOOL OFFICE SIGNED BY THE PHYSICIAN AND THE PARENT OR GUARDIAN. NO MEDICATION WILL BE ADMINISTERED WITHOUT THESE REQUIRED SIGNATURES.
THIS FORM IS VALID FOR THE ACADEMIC YEAR ONLY.