Central Unified School District
MEDICATION AT SCHOOL FORM

Student Name: ___________________________ D.O.B.: ____________ Teacher: _________________

Parent/Guardian Name: ____________________________ Phone: _____________ Grade: ___________

The Education Code defines certain requirements for the administration of medication in the school setting, including field trips and after school programs. A student can be allowed medication in the school setting if a Medication at School form has been completed and signed by parent and physician. **It is recommended at the beginning of each school year, or upon school entry, a Medication at School form must be completely renewed. If there is a change in the student's health status or medication regime the parent must notify the school immediately and a new form will be required.** Medication must be sent to school in the original pharmacy container and clearly labeled with student's name. No medications (including over the counter medications) will be given at school without a current Doctor prescription.

PARENT'S REQUEST

We the undersigned, who are parents/guardian of the above named student, request that the school nurse or designated school personnel assist the pupil, when necessary, in the matter set forth by the physician's orders. We hereby consent to self-administration, if authorized by the physician. Furthermore, we consent to appropriate school personnel consulting with the student's physician regarding the medication, if necessary. In the event of an untoward or subsequent reaction or any other damages or injuries suffered or incurred as a result of the student's self-administration of medication, our/my signature below constitutes a full waiver, release and hold harmless of the district and school personnel from any and all civil liability related to such claims. This parent authorization is good for one year from signature date.

Date: _______________ **Signature of Parent/Guardian:** __________________________________

PHYSICIAN'S ORDERS

Medication and Dose Prescribed	How Much to take.	Time per day... or as needed	How to Give It Oral/Inhaler/Other	Condition/Diagnosis or symptoms to look for.

This authorization is good for one year of signature date unless indicated: ______________________
This authorization has a stop date of (including summer school to July 31.): ______________________

If Prescribing Asthma Inhalers/Auto-Injectable Epinephrine such as Epi-Pen/Glucagon:
Does the student need to carry an asthma inhaler, Glucagon or Epi-pen on campus? Yes____ No____

I have instructed the student in the proper way to use his/her inhaler or epi-pen, including proper administration technique. It is my professional opinion that the student is able to self-administer the medication and should be allowed to carry and use the inhaler or epi-pen on campus.

Physician's Name (printed): ______________________________________ Date: ___________________

Physician's Signature:__________________________ **Phone:**_______________ **Fax**:________________

School Nurse: ____ Date: ___________________

School Name: _______________________________ Address: _______________________________________

Phone: ____________________________________ Fax: ____