PARENT/PHYSICIAN RELEASE FOR MEDICATION IN SCHOOL

Please Note: This form must be completed each school year.
Not to be used for Asthma inhalers.
To be used in *conjunction* with the FARE form for orders for epinephrine/anaphylaxis.

PROTOCOL GOVERNING THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL:

When it is necessary for students to take medications during the 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 signed in to the health office at school in the prescription bottle or original container.
- With the exception of prescription auto-injectable epinephrine and inhaled asthma medications, medication cannot be kept on student's person. Prescription auto-injectable epinephrine and inhaled asthma medications may only be kept on a student's person with written consent of the parent and physician pursuant to the RAFOS Administration of Medications Policy.

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 from 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.

PARENT REQUEST:

Student's last name	Student's first name	Date of birth	School	Grade

In agreeing to have the school administer my child's medication, I voluntarily agree to release, discharge and hold harmless Rocklin Academy Family of Schools 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. I acknowledge and understand the medication may be administered by a school nurse or by designated school personnel. I understand that I may terminate the consent for the administration of the medication or for otherwise assisting the student in the administration of mediation at any time. I have read and understand the RAFOS Administration of Medications Policy and understand medication will only be delivered consistent with this Policy. **I authorize the school to communicate with the physician below regarding my child's medical condition and/or medication prescribed for it.**

Parent/Guardian Signature:__________________________________ Date:__________Phone:______________

Additional Emergency Contact: _____________________________________ Phone:______________________

PARENT/PHYSICIAN RELEASE FOR MEDICATION IN SCHOOL

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:____

Medication Name:____ Dose:______________________

Frequency/Time to be given at school:____

Reason for Medication/Diagnosis:____

Possible Side Effects:____

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: ________________________________