AMADOR COUNTY UNIFIED SCHOOL DISTRICT

School_____ Phone#_____ Fax#_____

MEDICATION IN SCHOOL

Permission Form to Administer Medication in School

Student Name: _____ Date of Birth: _____ Grade: _____
Teacher: _____ Doctor: _____

Parent/Guardian Request for Administration of Medication
Prescription and Non-Prescription

California Education Code and Title 5 allow the School Nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain or improve his/her potential for education and learning.

- I request that medication be administered to my student in accordance with our physician's written instructions. (see below)
- I understand that the school nurse is not on campus daily and designated school personnel will administer medication under the supervision of a qualified School Nurse.
- I will ensure that the medication is delivered to the school in an original, labeled pharmacy container by myself or another responsible adult.
- I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or prescribing physician.
- I give permission to contact my student's physician for clarification and further information regarding this medication.
- I give permission for the school nurse to discuss with school personnel my student's medication needs.
- I acknowledge that I may terminate this consent at any time.
- I release the school district and school personnel from civil liability if the student suffers any adverse reaction by taking self-administered medication.

Parent/ Guardian Signature: _____ Date: _____

Physician's Request for Administration of Medication

Diagnosis/Reason for Medication: _____
Medication: _____ Dose: _____
Route: ☐Tablet ☐Liquid ☐**Inhaler*** ☐**Injection*** ☐Nebulizer ☐Other
Time: _____ If PRN: Amount of time between doses ____ Max number of doses per day___
Possible side effects: _____
***This student may carry his/her medication and is competent to self administer:** ☐YES ☐NO
***This student may carry an epi-pen and is competent to self administer this medication.** ☐YES ☐NO
This student has been instructed about the proper use and need for this medication: ☐YES ☐NO

- The above medication can not be scheduled for times other than school hours.
- This medication may be administered by non-medical school personnel under the supervision of a qualified School Nurse.

Physician's Signature: _____
Date of Request: _____ Date to Discontinue: _____
Physician's Name (Print): _____
Phone: _____ Address: _____

THIS REQUEST IS VALID FOR A MAXIMUM OF ONE SCHOOL YEAR