



Student Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

PARENT/GUARDIAN RESPONSIBILITIES AND STATEMENT

I, as a parent or legal guardian of the above listed student, request and understand the following in accordance with California Education Code sections 49423-49423.5 and the Department of Education in order for the student to take medication during school hours, school activities and field trips:

- My student will not be assisted with medication at school until all requirements are met.
I shall provide a new written authorized health care provider's statement with any changes in medication, dose, medical provider, time or discontinuation of medication.
I understand that a school nurse is not on campus daily. During his/her absence, a designated unlicensed trained school staff employee will administer or otherwise assist my student in the administration of below prescribed or over the counter medication.
Medication will be taken on all school activities and field trips during school hours unless otherwise directed.
All medication must be brought to the school by a parent/guardian in the original container, with a pharmacy label if applicable.
If agreed on by the students health care provider, I consent to allow my child to carry and self-administer the below medication and release the district and school personnel from civil liability if my student suffers an adverse reaction as a result of self-administering the medication.
This request for medication administration can be terminated at any time or for otherwise assisting the student in the administration of medication at any time.

Signature of Parent/Legal Guardian

Printed Name

Date

HEALTH CARE PROVIDER STATEMENT (To be completed by health care provider)

The child named above is under my care for the following medical diagnosis: _____

Table with 5 columns: Medication, Dose, Route, Time or Frequency, Duration. Includes checkboxes for Scheduled and PRN.

For PRN medication: Symptoms that would necessitate administration: _____

Indications for referral for medical evaluation: _____

Precautions or side effects: _____

- I confirm that it is medically necessary for the student to carry this medication on campus, and indicate one of the following:
Designated school personnel to administer to student
Student has been trained by healthcare provider to self-administer

Health Care Provider name/address/phone:

Signature of Health Care Provider

Date

PARENT/GUARDIAN

HEALTH CARE PROVIDER