



MEDICATION AT SCHOOL

CHILD'S NAME _____ B.D. _____

PARENT'S NAME _____

Dear Parent:

Education Code Section 49423 defines certain requirements for administration of medication. "... any pupil who is required to take, during the regular school day, medication prescribed for him or her by a physician and surgeon, may be assisted by the school nurse or other designated school personnel or may carry and self-administer inhaled asthma medication if the school district receives... (1) ...a written statement from the physician and surgeon detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken and (2) a written statement from the parent, foster parent, or guardian of the pupil requesting that the school district assist the pupil in the matters set forth in the statement of the physician and surgeon."

The medication must be clearly labeled and sent to school in a container from the pharmacy.

At the beginning of each school year or upon entry to a school a Medication at School form must be completely renewed.

PARENT'S REQUEST

We the undersigned, who are parents/guardian of _____, request that the school nurse or designated school personnel assist the pupil in matters set forth in the statement of the physician and surgeon. If so approved by the physician, we do consent that our child carry and self-administer inhaled asthma medication. In the event of an untoward, subsequent, adverse reaction, it is understood that the school personnel and the school district will not be held responsible or civilly liable for carrying out this request. We also give permission for the school nurse/designated school personnel to consult with the health care provider regarding any questions that may arise with regard to the medication listed below. We also agree to immediately notify the school nurse and/or designated school personnel if there is any change in the pupil's medication, dosage, hour, method of administration, time limit, or condition for administering.

Date: _____ Signature of Parent/Guardian: _____

Daytime phone number: _____

PHYSICIAN'S ORDERS

1. Medication including dosage, hour, method of administration and time limit: _____

2. Condition for which the medication is to be given (i.e., allergy, specific type of reaction: localized, generalized, mild, severe, etc.)

3. If applicable, I hereby confirm that this pupil is capable of self-administering prescribed inhaled asthma medication and keeping it on his/her person. Yes ___ No ___

Date: _____ Tele.# _____ Physician's Signature: _____

For additional information, please call school nurse _____ M T W T H F between the hours of _____ (telephone .#)

School Administrator

School Nurse Date

