PARENT/PHYSICIAN RELEASE FOR MEDICATION IN SCHOOL

PLEASE NOTE: THIS FORM MUST BE COMPLETED EACH SCHOOL YEAR

I. **POLICY GOVERNING THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL**:
When it is necessary for students to take prescription or over the counter medication during school hours the following procedure shall be followed:

1. Medication cannot be administered by school personnel unless there are completed parent and physician request forms on file in the school office.
2. Form to administer medication will then be kept with the medication in the school office.
3. The medication must be sent to the school in the prescription bottle or original container.
4. Medicine, both prescription and over-the-counter, shall not be kept on the student's person, lunch box, desk, or teacher's desk.

II. **BASIC LEGAL PROVISION** - California Education Code 49423 (1976)
Not withstanding the provision of Section 49423, any pupil who is required to take during the regular school day medication prescribed for him 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 method, 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 the matters set forth in the physician's statement.

III. **PARENT REQUEST** _____ _____ _____ _____
Last Name of Student First Name Birth Date Grade School

{ My child will need to take medication at school. It is to be given at _____ (time) with the following special instructions:

_____

{ My child needs to carry and self administer a metered dose inhaler.

In agreeing to have the school administer my child's medication, I voluntarily agree to release, discharge, and hold harmless Roseville City School District 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 causes my child's illness, injury, death, and damages of any nature in any way connected with the administration of my child's medication. ***I authorize the District to communicate with the physician below regarding my child's medical condition and/or the medication prescribed for it. .***

Parent/Guardian Signature _____ Date _____

Address _____ Home Phone _____ Work/Cell Phone _____

Emergency Contact _____ Phone _____

IV. **PHYSICIAN'S REQUEST**

Medication: _____
Dose form/strength (tablet, liquid, inhaler) _____
Reason for medication: _____
Dosage/Frequency or time to be given at school _____
Precautions or important side effects { None anticipated { Yes. Please describe _____
Special Storage Requirements _____
Additional information: { On the reverse side of this form { As an attachment

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Dose form/strength (tablet, liquid, inhaler) _____
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Precautions or important side effects { None anticipated { Yes. Please describe _____
Special Storage Requirements _____
Additional information: { On the reverse side of this form { As an attachment

Date**:** _____ **Physician's Signature** _____

Student has been instructed on correct use and may carry and self-administer metered dose inhalers: { Yes { No

_____
Physician must sign approval

PHYSICIAN'S NAME:

ADDRESS:

PHONE NUMBER:

PLEASE RETURN TO:
Eich Intermediate School
1509 Sierra Gardens Drive
Roseville, CA 95661
Fax Number 916-783-7292

_____ _____
Nurse's Signature **Principal's Signature**