School: ______________________ Phone: ____________________ Fax: __________________

PLEASANTON UNIFIED SCHOOL DISTRICT

PRESCRIPTION OR OVER THE COUNTER MEDICATION CONSENT FORM

TO BE COMPLETED BY PARENT:

Student's Name ____________________________ **Date of Birth** __________ **ID #**__________ **Grade** _____

Home Phone ________________ **Parent's Work/Cell Phone** ______________________________________

This form must be completely filled out and signed annually by the child's parent/guardian and the child's authorized health care provider before the child can be assisted with the administration of medication by District personnel at any school site.

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Name of the Medication ______ Dosage ______ Method ______ Schedule or Time the Medication Is Given ______

Purpose of the Medication ______ Duration ______

Special Instructions: (i.e. storage, restrictions, and important side effects) ______

Name of the Medication ______ Dosage ______ Method ______ Schedule or Time the Medication Is Given ______

Purpose of the Medication ______ Duration ______

Special Instructions: (i.e. storage, restrictions, and important side effects) ______

Print Health Care Provider's Name ______ **Health Care Provider's Signature** ______ **Date** ______

Street Address ______ **Phone number** ______

City ______ **State and Zip Code** ______ **Fax** ______

Pursuant to Education Code Section 49423, I authorize the teacher, principal, district nurse, health clerk or other designated school personnel to administer medication to my child according to the prescription/dosage instruction listed above.

I UNDERSTAND AND AGREE TO:

1. assume responsibility for getting my child's medication in its original prescription container, supplies, and equipment to the school office;
2. inform the school site personnel in writing of any important information or special instruction related to the administration of medication to my child;
3. immediately inform the school site personnel of any change in my child's regimen or authorizing health care provider and I am willing to complete a new form;
4. make certain that my child takes responsibility for taking the medication as prescribed;
5. split medication for correct dosage at home;
6. pick up all medication at the end of the school year; and
7. provide a release for the district nurse or other designated school personnel to consult with the prescribing health care provider and/or pharmacist regarding the medication.

I also agree that the District, its officers, employees and agents shall not be held liable for any loss, damage, injury or liability of any kind to any person caused or arising from acts, omissions or negligence of the District, its officers, employees and agents related to the administration of medication to my child.

I HAVE READ AND UNDERSTOOD THIS FORM AND CONSENT TO THE ABOVE PROVISIONS.

Parent/Guardian's Signature ________________________________ **Date** ____________________

Reviewed by ______________________ Date: ________ ☐ District Nurse ☐ Health Clerk Liaison ☐ Site Administrator

RE: PRESCRIPTION OR OVER THE COUNTER MEDICATION ADMINISTRATION CONSENT FORM

Dear Parent/Guardian:

Parents of students who require the administration of medication during the school day must have a **PRESCRIPTION OR OVER THE COUNTER ADMINISTRATION CONSENT FORM** on file in the school office.

This form must be completely filled out annually and signed by the parent/guardian and the child's health care provider before the child can be assisted with the administration of medication by the district personnel at the school site. The authorized health care provider must be licensed in California.

It is the parent/guardian's responsibility to provide the school site with all necessary information and special instructions in writing related to the administration of medication to their child. The parent/guardian must immediately notify the school in writing of any changes in the child's regimen or authorizing health care provider. It is also the child's responsibility to follow the health care provider's recommendations and instructions related to taking the medication (i.e., the child is responsible for going to the office at the prescribed times).

In signing the **PRESCRIPTION OR OVER THE COUNTER MEDICATION ADMINISTRATION CONSENT FORM,** the parent/guardian agrees to release from liability the district, its officers, employees and agents for any loss, damage injury or liability of any kind to any persons caused or arising from the acts, omissions or negligence of the District, its officers, employees and agents related to the administration of medication to their child, and to provide release for the district nurse or other designated school personnel to communicate with the health care provider and /or pharmacist of the pupil regarding any questions that may arise with regard to the medication.

Medication must be in its original container and brought to school by the parent/guardian, or an adult designee. All controlled medication will be counted and recorded on a medication log when delivered to school.

ALL medication must be picked up by a parent/guardian or adult designee at the end of the school year. **NO** medication will be given to a student to take home. Medication left in the school office at the end of the school year will be discarded.

If you have any questions, please contact the school office.

Revised 5/2007