

Parent Request for Administration of Medication

C.E.C. 49422. Notwithstanding the provisions of Section 49422, any pupil who 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 received (1) written statement from such physician detailing the method, amount and time schedules by which such medication is to be taken, and (2) written statement from the parent or guardian of the pupil indicating the desire that the school assist the pupil in the matters set forth in the physician's statement.

Physician's Request for Administration of Medication During School Hours

Student: _____ Birth Date: _____

Address: _____

Physical condition for which drug is given: _____

Name of Medication: _____

Dosage and method of administration: _____

Possible reaction that needs to be reported to physician: _____

Date of request: _____

Physician's Signature: _____

Phone: _____

Address: _____

Medication to be continued until: _____

Note: The very first dose of this medication for current condition/illness **may not be given at school.**

Parent Release for Administration of Medicine

It is understood that the school is not legally obligated to administer medication to my child; therefore, I agree to hold the CCS school and its' employees free from any or all suits which might arise out of these arrangements.

We, the undersigned, who are the parents of _____, request that medicine be administered to our child in accordance with the above request by a member of the school staff if the school nurse is not available. I will notify the school if the medication is changed or stopped. The medication to be taken at school will be furnished in its pharmacy-labeled bottle. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the end of the school year.

I give my consent for the school nurse to exchange medical information with the prescribing physician.

Date: _____ Parent Signature: _____

Phone: _____ Address: _____

Reviewed by RN: _____ Staff _____ may _____ may not administer

RN (Print Name)

RN Signature