

# AMADOR COUNTY UNIFIED SCHOOL DISTRICT

School \_\_\_\_\_ Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

---

## MEDICATION IN SCHOOL

*Permission Form to Administer Medication in School*

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_  
Teacher: \_\_\_\_\_ Doctor: \_\_\_\_\_

### Parent/Guardian Request for Administration of Medication Prescription and Non-Prescription

California Education Code and Title 5 allow the School Nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain or improve his/her potential for education and learning.

- I request that medication be administered to my student in accordance with our physician's written instructions. (see below)
- I understand that the school nurse is not on campus daily and designated school personnel will administer medication under the supervision of a qualified School Nurse.
- I will ensure that the medication is delivered to the school in an original, labeled pharmacy container by me or another responsible adult.
- I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or prescribing physician.
- I give permission to contact my student's physician for clarification and further information regarding this medication.
- I give permission for the school nurse to discuss with school personnel my student's medication needs.
- I acknowledge that I may terminate this consent at any time.
- I release the school district and school personnel from civil liability if the student suffers any adverse reaction by taking self-administered medication.

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Continued on next page

-----

