Parent/Physician's Statement

Student's Name: _____ D.O.B: _____ Date: _____
School: _____ Grade: __ Teacher: _____

Medication may be dispensed to students at school if the following information is completed and the parent/guardian agrees to the following terms and conditions. This form is valid for one (1) school year.

Name of medication _____ to be administered as directed by the physician designated below.

I understand the following:

1. A school nurse is not available to give medication and a staff member may be assigned to do so.
2. I am required to bring the medication to school personally (Preschool – 8th grade)
3. The medication will be labeled by a pharmacist and in the pharmaceutical container. The label will state student's name, date, name of medication, dosage, time(s) to be given, special instructions, and the physician's name.
4. Over-the-counter medication must remain in manufacturer's container and be marked with student's name
5. The school is not responsible for the results or side effects of the medication. In return for the school's assistance in administering the medication to my child, I hereby waive on my own behalf, and on the behalf of my child, the right to maintain any legal action for damages against the school for any adverse effect that the medication may have on my child.
6. I, hereby, consent to exchange information regarding this medication between _____ and the pharmacist and/or physician below. (name of campus)

In accordance with California Education Code #49423.

Parent/Guardian Signature: _____ Date: _____
Address: _____
Telephone (home): _____ (work) _____

TO BE COMPLETED BY PHYSICAN

Medication: _____
Dosage and route: _____
Time(s) to be dispensed at school: _____
Reason for medication: _____
Duration: _____
Special instructions/precautions: _____
Possible side effects: _____
Physician's Print Name/Signature: _____
Physician's License #: _____ Date: _____
Address: _____ Telephone: _____