

DUBLIN SCHOOLS

DUBLIN UNIFIED SCHOOL DISTRICT

Re: Medication Administration Consent Form

Dear Parent/Guardian:

Students who require the administration of medication during the school day pursuant to a physician's prescription must have a parent and physician signed Medication Administration Consent Form on file at the school site.

This form must be completely filled out annually or whenever the prescription changes, and must be signed by both the parent/guardian and the child's physician before the child can be assisted with the administration of prescription and nonprescription medication by district personnel at the school site.

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 physician. It is also the child's responsibility to follow the physician's recommendations and instructions related to taking the medication (i.e., the child is responsible for going to the school office at the prescribed times).

In signing the 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 person 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.

Medication must be in its original pharmacy labeled container and brought to school by the parent/guardian. **All** medication must be picked up by a parent 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 health clerk or District Nurse.

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MEDICATION ADMINISTRATION CONSENT FORM

This form must be completely filled out and signed annually or whenever the prescription changes, by the child's parent/guardian and the child's physician before the child can be assisted with the administration of any medication by District personnel at any school site.

Student's Name: _____ Grade: _____ Teacher: _____

DOB: _____ Home Phone: _____ Parent's Wk Phone: _____ School: _____

Name of Prescribing Physician: _____ Phone: _____

MEDICATION(S) PRESCRIBED AT SCHOOL:

1. Medication _____ Dosage _____ Time _____ Route _____

2. Medication _____ Dosage _____ Time _____ Route _____

3. Medication _____ Dosage _____ Time _____ Route _____

Any additional instructions or information that the school personnel should be aware of in the administration of the above medication(s): _____

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

I understand and agree to the following:

1. To assume responsibility for getting my child's medication in its original prescription container to the school office.
2. To inform the school site personnel in writing of any important information or special instructions related to the administration of medication to my child.
3. To immediately inform the school site personnel of any change in my child's regimen or authorizing physician and am willing to complete a new form.
4. To make certain that my child takes responsibility for taking the medication as prescribed.
5. If the medication needs to be broken (to give half the dosage), it must be broken at home by the parent. School staff will not take this responsibility.
6. To pick up all medication at the end of the school year.

I also agree that the District employees 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

Physician's Signature

Date

Physician may fax form to school. School fax number: _____