SAN JUAN UNIFIED SCHOOL DISTRICT
HEALTH SERVICES

PARENT/PHYSICIAN RELEASE FOR MEDICATION IN SCHOOL

BASIC LEGAL PROVISION - California Education Code, Section 49423, 49423.6 (2003)

Pursuant to Section 49423 and subdivision (b) of Section 49423.6 of the Education Code, any pupil who is required to take, during the regular school day, prescribed medication may be assisted by a school nurse or other designated school personnel if both of the following conditions are met: (a) The pupil's authorized health care provider executes a written statement specifying, at a minimum, the medication the pupil is to take, the dosage, and the period of time during which the medication is to be taken, as well as otherwise detailing (as may be necessary) the method, amount, and time schedule by which the medication is to be taken. (b) The pupil's parent or legal guardian provides a written statement initiating a request to have the medication administered to the pupil or to have the pupil otherwise assisted in the administration of the medication, in accordance with the authorized health care provider's written statement.

POLICY GOVERNING THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL
SJUSD Policy #BP 5141.21 (1991)

It is the policy of the San Juan Unified School District to cooperate with the pupil's parent/guardian and his/her physician by administering and providing a safe place for the storage of medication deemed necessary for pupils who have potentially life-threatening medical conditions or who need medication administered during the school day in order to interact appropriately in the school setting. Selected school personnel may store and/or dispense such prescribed medication to pupils upon written request of the pupil's parent/guardian and physician only when the medication is in the original container.

INSTRUCTIONS:

In order for a student to receive medication at school or during school-related activities, the following criteria must be met:

- A new form must be completed **each** school year for **each** medication. A new form must also be completed whenever there is a change in the medication: name, form (tablet, capsule, liquid), dose (amount), or time given. If there are no changes, each form is good from August 1 of one year until July 31 of the following year.
- A form is required for **any** medication, prescription, non-prescription, or herbal supplement.
- **Both parent/guardian and physician must complete and sign this form**.
- All medication must be in the original container or original unopened package, and prescription medication must have the current prescription label.
- The original form **must** be on file at school. Forms may be brought to school by parent, guardian, or care provider. The completed form may also be mailed to the school.

PARENT REQUEST (Please Print): **School Year: _____**

Student: _____ Date of Birth: _____ Grade: _____

Parent/Guardian: _____ Phone: _____

Address: _____ School: _____

_____ School Phone: _____

If parent/guardian is unavailable, emergency contact:

Name: _____ Relationship: _____ Phone(s): _____

My child will need to take _____ (medication) at school. It is to be given at: _____ (time) with the following special instructions: _____.

I the undersigned, who is the parent/guardian of the above named student, request that medication be administered to said child by a designated member of the school staff, in accordance with instructions outlined on the reverse side and authorized by our physician.

I give my permission for the principal, or designee, to communicate, with my child's physician regarding the physician's written statement for medication administration.
I understand that the major responsibility for a child taking medication rests with the child and his/her parent/guardian, and that I am required to personally bring the medication to school (preschool through 6th grade). I understand that students in grades 7 through 12 may bring their own medication to the school office.

I understand that I must notify the school office, in writing, if I wish to terminate the request for administration of medication.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

STUDENT: _____ **DATE OF BIRTH:** _____

PHYSICIAN INFORMATION (Print):

- Name of Medication: _____
- Reason for Medication: _____
- Dosage: _____
- Time: _____
- Route: ☐ Oral ☐ Inhalation ☐ Injection ☐ Topical ☐ Other: _____
- Possible Side Effects: _____
- Special Instructions/Precautions: _____

Will student need to personally carry this medication? Yes ☐ No ☐
Will the student be "self"-administering this medication: Yes ☐ No ☐
The listed medication is necessary for: ☐ a potentially life-threatening condition
☐ appropriate pupil interaction in school setting

Physician's Name (Print): _____

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

_____ Fax: _____

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PARENT REQUEST FOR MEDICATION SELF ADMINISTERED BY STUDENT AND REQUIRING SPECIAL STORAGE

Student's Name: _____ Birth Date: _____ Grade: _____ School: _____

I, the undersigned, who is the parent/guardian of the above named student, request and authorize the staff of _____ (school) to store my child's medication at the school site. As indicated in the physician's statement above, my child will self-administer his/her own medication when required, and I am not requesting school personnel to assist in the administration of my child's medication.

My child will need to self-administer his/her medication at school because he/she suffers from the following condition: _____ .

My child will need to take his/her medication _____ (number of times per day) with the following special instructions: _____ .

I request that my student's medication be stored in the following manner: _____
(*type of storage required).*

I understand that in order to have my child's medication stored at the school, I am required to place the medication in a locked container to which only my child will have access. Such container must be provided prior to the school's consenting to the storage of the medication.

Parent/Guardian Signature: _____ Date: _____

Address: _____ Home Phone: _____ Work Phone: _____

_____

Emergency Contact: _____ Relationship: _____ Phone: _____