Central Unified School District
MEDICATION AT SCHOOL FORM

Student Name: _____ D.O.B.: _____Teacher: _____

Parent/Guardian Name: _____ Phone: _____ Grade:_____

The Education Code defines certain requirements for the administration of medication in the school setting, including field trips and after school programs. A student can be allowed medication in the school setting if a Medication at School form has been completed and signed by parent and physician annually. If there is a change in the student's health status or medication regime the parent must notify the school immediately. Medication must be sent to school in the original pharmacy container and clearly labeled with student's name. **No medications (including over the counter medications) will be given at school without a current Doctor prescription.**

PARENT'S REQUEST

We the undersigned, who are parents/guardian of the above named student, request that the school nurse or designated school personnel assist the pupil, when necessary, in the matter set forth by the physician's orders. We hereby consent to self-administration, if authorized by the physician. **Furthermore, we consent to appropriate school personnel consulting with the student's physician regarding the medication, if necessary.** In the event of an untoward or subsequent reaction or any other damages or injuries suffered or incurred as a result of the student's self-administration of medication, our/my signature below constitutes a full waiver, release and hold harmless of the district and school personnel from any and all civil liability related to such claims. **This authorization is good for one year from signature date.**

Date: _____ Signature of Parent/Guardian: _____

PHYSICIAN'S ORDERS

Medication/Dose Prescribed	How Much to take.	What Time per day-every day?	How to Give It Oral/Injection?	Condition/Diagnosis or symptoms to look for.

If Prescribing Asthma Inhalers/Auto-Injectable Epinephrine such as Epi-Pen/Glucagon:
Does the student need to carry an asthma inhaler, Glucagon or Epi-pen on campus? Yes☐ No☐

I have instructed the student in the proper way to use his/her inhaler or epi-pen, including proper administration technique. It is my professional opinion that the student is able to self-administer the medication and should be allowed to carry and use the inhaler or epi-pen on campus.

Physician's Name (printed): _____ Date: _____

Physician's Signature: _____Phone: _____

School Nurse: _____Date: _____

School Name: _____ Phone: _____ Fax: _____

MASform Updated 3-26-15 blv

El Distrito Unificado Central (Central Unified School District)
FORMA DE MEDICACIÓN EN LA ESCUELA/Medication at School Form

Nombre del Estudiante: _____ Fecha de Nacimiento: _____ Maestro/a: _____

Nombre del Padre/Guardián: _____ Teléfono: _____ Grado :_____

El Código Educacional establece ciertos requisitos para la administración de medicina en la escuela. Se puede permitir al estudiante medicina en la escuela si la forma de Medicación en la Escuela esta completa y firmada por el padre y un doctor annualmente.
Si hay algún cambio en la salud del estudiante o duración de la administración del medicación, la escuela debe ser notificada inmediatamente. El medicación debe ser enviado a la escuela en el contenedor original de la farmacia y claramente etiquetado con el nombre del estudiante. **No se podran administrar medicaciónes (incluyendo medicaciónes disponibles al comprador) en la escuela sin una receta médica actual.**

SOLICITUD DE LOS PADRES

Nosotros los que firmamos, quienes somos los padres/guardián del estudiante antes mencionado, solicitamos que la enfermera de la escuela ó el personal escolar designado pueda ayudar al estudiante, cuando sea necesario, de la siguiente manera por indicaciones del doctor. Aquí damos nuestro consentimiento a la auto-administración, si es autorizada por el doctor. **Además damos nuestro consentimiento al personal escolar apropiado, en caso de ser necesario, a que consulten con el doctor del estudiante con referencia al medicación.**
En caso de una subsecuente reacción o lesión sufrida como resultado del medicación auto-administrado por el estudiante, nuestra/mi firma abajo constituye una exoneración o absolución de responsabilidad al distrito y al personal escolar de cualquier obligación civil relacionada a las demandas mencionadas.

Fecha: _____ Firma delPadre/Guardián_____

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Physician's Name (Printed): _____ Date: _____

Physician's Signature: _____Phone: _____

School Nurse: _____ Date: _____

School Name: _____ Date: _____

School Address:_____ Phone/FAX:_____

MASform Updated 3-26-15 blv