STUDENT HEALTH, WELLNESS & PREVENTION
PARENT RELEASE
FOR THE ADMINISTRATION OF MEDICINE

Student Name _____ Birth Date _____ Grade _____

Address _____ Home Phone _____ Work Phone _____

PARENT CONSENT

I(we), the undersigned, the parent(s)/guardians of the above named pupil, request the following medication be administered to my(our) child/ren in accordance with the California Education Code 49423.5.

I will: 1. Provide all medication, supplies, and equipment.
2. Notify the school nurse if there is a change in the pupil's health status or attending physician.
3. Notify the school nurse immediately and provide a new consent form for any changes in the doctor's orders.
4. I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN MEDICATION IT MUST BE ON HIS/HER PERSON IN ORDER TO ATTEND A FIELD TRIP.

I authorize the school nurse to communicate with the Authorized Health Care provider when necessary in regards to this specific medication and medical condition.

Parent/Guardian Signature_____**DATE**_____

HEALTHCARE PROVIDER REQUEST
FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNNEL

1. Diagnosis:_____
2. Medication:_____
3. Dose: _____
4. Method of Administration: _____
5. Time medication is to be given at school:(If appropriate please provide a range e.g. every 2-4 hours)

   _____
6. Possible reactions or side effects of medication:_____
7. Possible side effects or reactions that need to be reported to the physician (e.g., allergic reaction and treatment). _____

Authorized Consent For Medication Administration At School

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance to CA state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for the maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

Physician's Signature: _____Date_____
Address:_____ Telephone: _____

Nurse's Signature: _____ Date: _____

3/12 jh/blm