Sequoia Union High School District

MEDICATION FORM (One Medication Per Form)

Dear Parent/Caregiver:
California Education Code 49423 provides that students required to take medically prescribed or over-the-counter medications during the school day MAY be assisted by school personnel ONLY if the school district receives a specific written statement from the health care provider AND the parent or caregiver of the student. Please complete this entire form and return it to the School Nurse.

IF POSSIBLE, PLEASE SCHEDULE MEDICATION OUTSIDE OF SCHOOL HOURS.

==========HEALTH CARE PROVIDER SECTION==========
PLEASE PRINT

Student Name: Last, First Middle	Date of Birth (Month/Date/Year)
Health Condition for which medication is prescribed	Medication, Dose, Frequency, Duration
How is medication to be given? ☐ By mouth ☐ Inhalator ☐ Injection ☐ Other:	About what time does medication need to be given at school? _____AM/PM
The medication is to be continued as above until: (please be as specific about date)	Any precautions that school personnel need to know? Contraindications?
What are possible reactions or side effects?	What should be done in the event of reaction/side effect?
Check one below: ☐ I authorize this student to self-administer the above medication. ☐ I authorize designated school personnel to administer the above medication.	
Printed name and address of Health Care Provider or stamp	Signature of Health Care Provider

==========PARENT/CAREGIVER SECTION==========
PLEASE PRINT

Student Name: Last First Middle	Date of Birth (Month/Date/Yr)
Parent/Caregiver Name: Last/First Home Language	Parent Daytime Telephone
Address: Street, Apartment Number City/Zip Code	Parent Evening Telephone
School:	School Hours:
Check one below: ☐ I permit my child to give him/herself the above medication. ☐ I permit designated school personnel to give my child the above medication.	

1. I agree to hold the School District and its employees harmless from any and all liability for the results of taking the medication or the manner in which the medication is given.
2. I will reimburse the School District and its employees for any liability arising out of these arrangements.
3. I will notify the School Nurse immediately if there is a change in my child's medication schedule or if the Health Care Provider prescribing the medication is no longer providing health care for my child.
4. I understand it is my responsibility to send the medication to school in the original pharmacy container labeled with my child's name and the health care provider's instructions.
5. I understand that this form automatically expires at the end of each school year.

Parent/Caregiver Signature	Date