DUBLIN SCHOOLS

DUBLIN UNIFIED SCHOOL DISTRICT

MEDICATION AUTHORIZATION & CONSENT FORM

Dear Parent/Guardian:

Students who require assistance with medication during the school day pursuant to a physician's prescription must have a parent and physician signed Medication Authorization and 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 Authorization and 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 Services Assistant or District Nurse.

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MEDICATION AUTHORIZATION & CONSENT FORM

Last Name_____ First Name _____ DOB _____

School _____Grade _____ School Year _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

******NO RANGES WILL BE ACCEPTED, (EXAMPLE 5-10ML) EXACT DOSAGE REQUIRED******

1) Medication_____Dose/Route_____Time_____

Frequency_____ For ***as needed***, please list symptoms_____

[ ]Generic OK Additional Info_____

2) Medication_____Dose/Route_____ Time_____

Frequency_____ For ***as needed***, please list symptoms_____

[ ]Generic OK Additional Info_____

3) Medication_____Dose/Route_____ Time_____

Frequency_____ For ***as needed***, please list symptoms_____

[ ]Generic OK Additional Info_____

STAMP

PHYSICIAN SIGNATURE_____

DATE_____

TO BE COMPLETED BY PARENT/GUARDIAN

- I authorize school personnel to assist with the above medication for my child according to physician instruction. I understand that trained, non-medical personnel may assist with this medication (Ed Code Sec 49423 and 49480).
- This form must be renewed whenever the prescription changes and at the beginning of each school year.
- I understand that it is my responsibility to bring medication to health office in pharmacy labeled container and that medications must not be expired. All medications and supplies must have student's name clearly marked.
- While the school will make every effort to cooperate, the student must assume responsibility for coming to the office for medication.
- I request that my child have above prescribed medications on field trips or in case of disaster**,** according to physician instruction. All over the counter medications must be included in prescription.
- I understand that by signing below I agree 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 assistance of medication to my child.
- I authorize District Nurse/School Personnel to communicate with my child's health care provider for clarification purposes.
- I have read and understand the letter attached to this consent form.

PARENT/GUARDIAN SIGNATURE_____ **DATE**_____

Cell Phone #_____ **Home Phone#** _____**Work Phone#**_____