CAMPBELL UNION HIGH SCHOOL DISTRICT
PERMISSION AND INSTRUCTIONS TO ADMINISTER MEDICATION

Dear Parent/Guardian:

Before your child can receive assistance in taking medication during school hours, it is necessary to have specific written orders from your physician and written authorization from you. The school MUST be notified immediately of any changes of medication at school. In addition, we ask that you notify us of any changes in the medication taken at home which might affect your child's behavior at school. **Medication must be in Pharmacy Labeled container with the students name clearly visible**. Permission must be renewed each school year. Over-the-counter medication will be given only if prescribed by a physician or dentist. (California Education Code Section 49423 and 49423.1)

Name of Student:______________________________ Address:______________________________

Birthdate:______________ School:____________________ Program (if applicable):__________

To Be completed by Physician

The above named student is currently under my care and receiving medication(s) for the following condition(s):

____

____

MEDICATIONS(S) TO BE ADMINISTERED AT SCHOOL DURING SCHOOL HOURS:

1. DRUG:______________________________DOSE:_________AMOUNT:____________TIME:_________

   ROUTE:____

   OBSERVABLE ADVERSE REACTIONS THAT MIGHT BE SEEN AT SCHOOL:

   ____

   MEDICATION WILL CONTINUE FOR: ☐ DAYS ☐ MONTHS ☐ UNTIL:__________

2. DRUG:______________________________DOSE:_________AMOUNT:____________TIME:_________

   ROUTE:____

   OBSERVABLE ADVERSE REACTIONS THAT MIGHT BE SEEN AT SCHOOL:

   ____

   MEDICATION WILL CONTINUE FOR: ☐ DAYS ☐ MONTHS ☐ UNTIL:__________

The school reserves the right to contact the doctor regarding clarification if you are not available.
NOTE TO PARENT: It is your responsibility to provide the required medication(s) in individual prescription labeled container(s).

AUTHORIZING SIGNATURES: PERMISSION TO GIVE THE ABOVE MEDICATION(S) IS HEREBY GIVEN TO THE INSTRUCTIONAL STAFF AT: ______________________________

Physician Signature: __________________________Phone:____________________ Date: _______

Parent/Guardian Signature: ____ Date: _______

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CAMPBELL UNION HIGH SCHOOL DISTRICT

Authorization for Student to Carry and Self-Administer Medication in School

TO BE COMPLETED BY PHYSICIAN

Date:_________

I certify that ____, D.O.B. _____________,
(Student's Name)

must carry ____ with him/her at all
(Name of Medication)

times at school due to ____.
(Medical Condition)

Drug: ____________________________________ Amount:: ______________________

Route: ___________________________________ Time: _________________________

This condition is such that there is inadequate time for the student to go to the office to obtain the medication. I have instructed the student in the proper administration of this medication and have certified that he/she needs no adult supervision. I have further instructed the student in the dangers of giving the medication to anyone other than himself/herself. I have discussed the above stated risks and liabilities with the parent.

I understand that the school nurse or other designated school personnel may be contacting my office with questions reguarding the medication. If student's parent/foster parent/guardian has provided consent to do so, my staff or I will discuss medication issues with such school personnel. This statement is valid for the current school year only, or until a new statement is necessary for the current school year because of a change in medication, dosage, frequency of administration, or reason for the administration.

____ ____________________
Physician's Signature Date

____ ____________________
Physician's Name Phone

TO BE COMPLETED BY PARENT/GUARDIAN

I permit my child to carry the above listed medication as ordered/approved by his/her physician. I have fully instructed my child on the proper administration of this medication and certify that he/she does not need adult supervision. I accept responsibility for the appropriate use of this medication and certify that he/she does not need adult supervision. I accept responsibility for the appropriate use of this medication by my child. I am aware of the risks to my child and other children and assume responsibility for any liability related to the misuse of this medication by my child or by other children. NOTE: For students who use auto-injectable epinephrine or inhaled asthma medication, please see attached authorization and release.

____ ____________________
Parent Signature Date

____ ____________________
Home Phone Work Phone

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