GLENDORA UNIFIED SCHOOL DISTRICT
Department of Health Services
301 South Loraine Avenue, Glendora, CA. 91741
Phone: (626) 852-4589 Fax: (626) 852-4585 • Web Site www.glendora.k12.ca.us

CONSENT FOR SELF-ADMINISTRATION OF MEDICATION

_____ _____
*Student's Name *Student's Date of Birth

_____ _____ _____
*School *Grade *Allergies

PARENTAL CONSENT FOR STUDENT TO SELF-ADMINISTER MEDICATION TO BE COMPLETED BY PARENT OR GUARDIAN

This form is valid for one year (Ed Code 49423).

- Any pupil who is to take medication prescribed by a physician may be assisted by a school nurse or other designated school personnel. This accommodation is provided when the schedule of medication would otherwise require the pupil to remain home, when medication is needed for emergency situations, or for specific health reasons. As a Parent/Legal Guardian, I have the right to come to school and administer medication to my child if I feel it is necessary. Students may self-administer medication at school when the Parent/Legal Guardian, physician, and school nurse determine the student is competent to do so.
- Parent/Legal Guardian is required to bring the medication to school and pick up any unused medication at the end of the school year.
- Medication administered at school must be provided in its pharmacy-labeled bottle or in original pharmacy labeled injectable medication kit. The label shall state: student's name, date, name of medication, dosage, time (s) to be given, special instructions and the physician's name. Parent/Legal Guardian must provide appropriate dosage measuring device, especially for liquid medications. Over the counter medication must remain in manufacturer's container and be marked with the student's name.
- Parent/Guardian has an obligation to report to the Glendora Unified School District (GUSD) a new consent form if student's medication, dosage, frequency of administration, or reason for administration changes during the school year.
- GUSD cannot be held responsible for missed or refused doses, side effects caused by the medication or any other problems. The parent/guardian waives any claim for injury against the school district, or its employees, arising from the administration of the medication as prescribed.
- Parent/guardian consents to the disclosure of their child's individually identifiable health information by physician to a school nurse or other personnel designated by the GUSD for the purpose of consulting with the physician regarding any questions that may arise with regard to the medication.

I, on behalf of myself, my child, our heirs, executors, and assigns, hereby agree to hold harmless, release, and covenant not to sue the Glendora Unified School District, its officers, employees, and agents for any and all liability, claim, or cause of action of any nature whatsoever, including by not limited to personal injury or death, which may result from my child's self-administration of medication.

***Parent/Guardian Signature** ***Parent/Guardian Printed Name** ***Date** ***Phone Number**

Self-Administered Medication Consent by Parent:

I also hereby consent to allow: _____(student) to self-administer the following medication during the regular school day or while at school-related activities: _____auto-injectable epinephrine _____ inhaled asthma medication _____ diabetes self-care (please see provider's orders regarding details related to self-administration of diabetes care at school)

*Signature: _____ *Date: _____

PHYSICIAN'S WRITTEN AUTHORIZATION BELOW TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER

Name of Medication (as prescribed): _____
Dosage: _____Method of Administration:_____ time: _____
Duration:_____ Health Condition for medication: _____
Special Instructions:_____
Pursuant to Education Code sections 49423, 49423.1, and/or 49414.5 I confirm that _____(student) is able to self-administer the above medication.(Auto-injectable epinephrine, inhaled asthma medication or perform diabetes self-care per doctor's orders). A new consent form will be required if student's medication, dosage, frequency of administration, or reason for administration changes during the school year. The current authorization will be effective for one school year.

I, _____, certify that the forgoing is true and correct.
* Physician's Name (print)

_____ _____
*Physician's Signature *Date

_____ _____ _____
*Address *City/Zip *Telephone

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INSTRUCTIONS

If you want your child to **SELF-ADMINISTER** an asthma inhaler, injectable epinephrine, or perform diabetes self-care while at school please complete these steps:

Step 1: Take this form "Consent for Self-Administration of Medication" to your health care provider. (If your student needs to take other prescribed medications at school, please see the "Consent for Prescribed Medications Administered in School" form).

Step 2: Your health care provider must complete the form(s) correctly.

Step 3: Check the label on the medicine and the form the health care provider fills in. The name of the medicine, strength of the medicine, dosage, schedule, and child's name all must match the form(s) and the health care provider must sign the form(s).

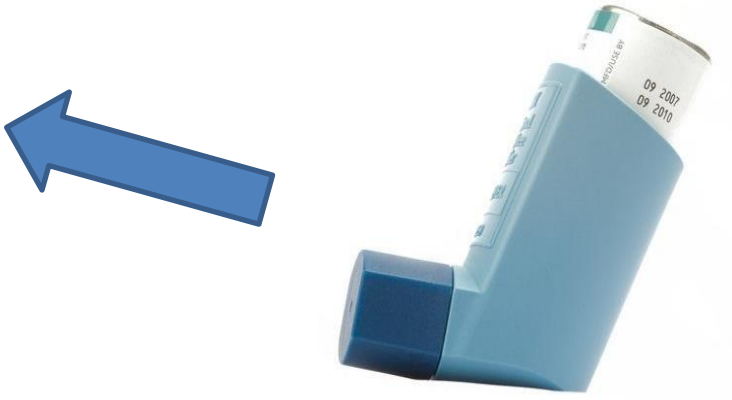
Step 4: As the parent or guardian, you must sign all form(s) and give this to your child's school.

Step 5: It is your responsibility as the parent to dispose of all empty medication containers.

Examples:

Medication 1

Health condition/diagnosis: Asthma
Medication name: Albuterol Inhaler
Dose: 90 mcg, 2 puffs every 4 to 6 hours as needed
Route/method: inhaled
Duration of administration: PRN for asthma symptoms



Medication 2

Health condition: Anaphylactic reaction to Bee Stings
Medication name: Epinephrine
Dose: 0.15 mg
Route/Method: injected into outer thigh
Duration of administration: PRN for anaphylactic reaction after bee stings