WESTERN PLACER
UNIFIED SCHOOL DISTRICT
600 Sixth Street, Suite 400, Lincoln, CA 95648 Ph: 916-645-6350

Administration of Medication Form

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

PARENT/GUARDIAN RESPONSIBILITIES AND STATEMENT

PARENT/GUARDIAN

I, as a parent or legal guardian of the above listed student, request and understand the following in accordance with California Education Code sections 49423-49423.5 and the Department of Education in order for the student to take medication during school hours, school activities and field trips:

- My student will not be assisted with medication at school until all requirements are met.
- I shall provide a new written authorized health care provider's statement with any changes in medication, dose, medical provider, time or discontinuation of medication.
- I understand that a school nurse is not on campus daily. During his/her absence, a designated unlicensed trained school staff employee will administer or otherwise assist my student in the administration of below prescribed or over the counter medication.
- Medication will be taken on all school activities and field trips during school hours unless otherwise directed.
- All medication must be brought to the school by a parent/guardian in the original container, with a pharmacy label if applicable.
- If agreed on by the students health care provider, I consent to allow my child to carry and self-administer the below medication and release the district and school personnel from civil liability if my student suffers an adverse reaction as a result of self-administering the medication.
- This request for medication administration can be terminated at any time or for otherwise assisting the student in the administration of medication at any time.
- ***If your child has a food allergy please have your doctor complete a Meal Accommodation form.**

_____ _____ _____

Signature of Parent/Legal Guardian | Printed Name | Date

HEALTH CARE PROVIDER STATEMENT (To be completed by health care provider)

HEALTH CARE PROVIDER

The child named above is under my care for the following medical diagnosis: _____

Medication	Dose	Route	Time or Frequency	Duration
☐ Scheduled ☐ PRN				
☐ Scheduled ☐ PRN				

For PRN medication: Symptoms that would necessitate administration: _____

Indications for referral for medical evaluation: _____

Precautions or side effects: _____

☐ **I confirm that it is medically necessary for the student to carry this medication on campus, and indicate one of the following:**

☐ Designated school personnel to administer to student

☐ Student has been trained by healthcare provider to self-administer

_____ _____

Signature of Health Care Provider | Date

Health Care Provider name/address/phone: