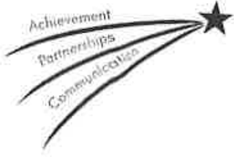
Pleasanton Unified School District



School: _________ Phone: ___________ Fax: ___________

RE: PRESCRIPTION OR OVER THE COUNTER MEDICATION ADMINISTRATION CONSENT FORM

Dear Parent/Guardian:

Parents of students who require the administration of medication during the school day must have a **PRESCRIPTION OR OVER THE COUNTER MEDICATION ADMINISTRATION CONSENT FORM** on file in the school office.

This form must be completely filled out each school year and signed by the parent/guardian and the child's health care provider before the child can be assisted with the administration of medication by the district personnel at the school site. The authorized health care provider must be licensed in California.

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 health care provider. It is also the child's responsibility to follow the health care provider's recommendations and instructions related to taking the medication (i.e., the child is responsible for going to the office at the prescribed times).

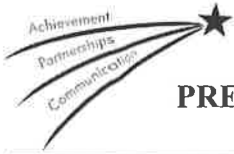
In signing the **PRESCRIPTION OR OVER THE COUNTER MEDICATION ADMINISTRATION CONSENT FORM,** the parent/guardian gives permission to the district nurse or other designated school personnel to communicate with the health care provider and /or pharmacist of the pupil regarding any questions that may arise with regard to the medication.

Medication must be in its original container and brought to school by the parent/guardian, or an adult designee. All controlled medication will be counted and recorded on a medication log when delivered to school.

ALL medication must be picked up by a parent/guardian or adult designee 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 office.

Pleasanton Unified School District School: __________ Phone: ___________ Fax: ___________



PRESCRIPTION OR OVER THE COUNTER MEDICATION CONSENT FORM

TO BE COMPLETED BY PARENT:

Student's Name ______________________________ **Date of Birth** __________ **ID #**__________ **Grade** ____

Home Phone ______________ **Parent's Work/Cell Phone** ____

This form must be completely filled out and signed each school year by the child's parent/guardian and the child's authorized health care provider before the child can be assisted with the administration of medication by District personnel at any school site.

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Name of the Medication ____________ Dosage ____________ Route ____________ Schedule or Time the Medication Is Given ____________

Purpose of the Medication ____________ Duration ____________

Special Instructions: (i.e. storage, restrictions, and important side effects) ____________

Name of the Medication ____________ Dosage ____________ Method ____________ Schedule or Time the Medication Is Given ____________

Purpose of the Medication ____________ Duration ____________

Special Instructions: (i.e. storage, restrictions, and important side effects) ____________

Medical Office Stamp

Health Care Provider's Signature ____________ Date ____________

Pursuant to Education Code Section 49423, I authorize in the absence of a School Nurse, designated trained unlicensed school personnel to assist with medication administration for this student according to the prescription/dosage/schedule instructions listed above.

Pursuant to Education Code 49423, I authorize in the absence of a school nurse, designated trained unlicensed school personnel to assist with medication administration for my child according to the prescription/dosage/schedule instructions listed above.

I UNDERSTAND AND AGREE TO:

1. assume responsibility for getting my child's medication in its original prescription container, supplies, and equipment to the school office
2. inform the school site personnel in writing of any important information or special instruction related to the administration of medication to my child
3. immediately inform the school site personnel of any change in my child's regimen or authorizing health care provider and I am willing to complete a new form
4. make certain that my child takes responsibility for taking the medication as prescribed
5. split medication for correct dosage at home
6. pick up all medication at the end of the school year
7. this document provides a release for the district nurse or other designated school personnel to consult with the prescribing health care provider and/or pharmacist regarding the medication

I HAVE READ AND UNDERSTOOD THIS FORM AND CONSENT TO THE ABOVE PROVISIONS.

Parent/Guardian's Signature ______________________________ **Date** ______________

Reviewed by ______________________________ Date: ____________ ☐ District Nurse ☐ Site Administrator