AMADOR COUNTY UNIFIED SCHOOL DISTRICT

MEDICATION IN SCHOOL

Permission Form to Administer Medication in School

Student Name: _________________________________ Date of Birth: _______ Grade: _____
Teacher: ______________________________ Doctor: _______________________________

Parent/Guardian Request for Administration of Medication

Prescription and Non-Prescription

California Education Code and Title 5 allow the School Nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain or improve his/her potential for education and learning.

- I request that medication be administered to my student in accordance with our physician’s written instructions. (see below)
- I understand that the school nurse is not on campus daily and designated school personnel will administer medication under the supervision of a qualified School Nurse.
- I will ensure that the medication is delivered to the school in an original, labeled pharmacy container by me or another responsible adult.
- I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or prescribing physician.
- I give permission to contact my student’s physician for clarification and further information regarding this medication.
- I give permission for the school nurse to discuss with school personnel my student’s medication needs.
- I acknowledge that I may terminate this consent at any time.
- I release the school district and school personnel from civil liability if the student suffers any adverse reaction by taking self-administered medication.

Parent/Guardian Signature: ________________________________________ Date: __________

Continued on next page
Physician’s Request for Administration of Medication

Diagnosis/Reason for Medication: __________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Medication: ___________________________ Dose: ________

*PRN Indication:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Route: ☐ Tablet ☐ Liquid ☐ Inhaler* ☐ Injection* ☐ Nebulizer ☐ Other

Time: ________ If PRN: Amount of time between doses ____ Max number of doses per day____

Possible side effects: ______________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

*This student may carry his/her medication and is competent to self administer: ☐ YES ☐ NO

*This student may carry an epi-pen and is competent to self administer this medication. ☐ YES ☐ NO

This student has been instructed about the proper use and need for this medication: ☐ YES ☐ NO
● The above medication can not be scheduled for times other than school hours.
● This medication may be administered by non-medical school personnel under the supervision of a qualified School Nurse.

Physician’s Signature: ___________________________________________________________
Date of Request: _________________________________ Date to Discontinue: _____________

Physician’s Name (Print): ________________________________________________________
Phone: ____________ Address: _____________________________________________________

THIS REQUEST IS VALID FOR A MAXIMUM OF ONE SCHOOL YEAR
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