SEBASTOPOL INDEPENDENT CHARTER SCHOOL

PO Box 1170, Sebastopol, CA, 95473, (707) 824-9700

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student: _____ Birth Date: _____
School/District: _____ Teachers Name: _____ Grade/Track: _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical 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 child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel will administer medication under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen and asthma inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back up medication should be kept at school for emergency use. I release the District and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering the medication.

Parent/Guardian Signature: _____ Date: _____

Telephone: (Work) _____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication: _____ Dose: _____ Route: _____ Time: _____

If PRN: Amount of time between doses _____ Maximum number of doses _____ per day.

Possible medication reactions: _____

Instructions for emergency care _____

Authorized Health Care Provider Signature: _____

Telephone _____

Date of Request: _____

Date To Discontinue Medication: _____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency EpiPen/Inhalers. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:

Reviewed by: _____ Date: _____

This request is valid for a maximum of one year.