

ROCKLIN ACADEMY

PARENT RELEASE FOR THE ADMINISTRATION OF MEDICINE

Student Name	Birth Date	Grade
Address	Home Phone	Work Phone

PARENT CONSENT

I(we), the undersigned, the parent(s)/guardians of the above named pupil, request the following medication be administered to my(our) child in accordance with the California Education Code 49423.5.

I will: 1. Provide all medication, supplies, and equipment.

2. Notify the school if there is a change in the pupil's health status or attending physician.

3. Notify the school immediately and provide a new consent for any changes in the doctor's orders.

4. I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN MEDICATION IT MUST BE ON HIS/HER PERSON IN ORDER TO ATTEND A FIELD TRIP.

I authorize the school to communicate with the Authorized Health Care provider when necessary in regards to this specific medication and medical condition.

Parent./Guardian Signature _____ DATE _____

HEALTHCARE PROVIDER REQUEST

FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

1. Medication: _____
2. Diagnosis: _____
3. Dose: _____
4. Method of Administration: _____
5. Time medication is to be given at school:(If appropriate please provide a range i.e. q.2-4 hours)

6. Possible reactions or side effects of medication: _____
7. Possible side effects or reactions that need to be reported to the physician (e.g., allergic reaction and treatment). _____

Authorized Consent For Medication Administration At School

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance to CA state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel. This authorization is for the maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

Physician's Signature: _____ Date _____
Address: _____ Telephone: _____

Principal's Signature: _____ Date: _____