UNIVERSITY HIGH SCHOOL
MEDICATION AT SCHOOL FORM

Student Name: ____________________________ D.O.B.: __________Teacher: _________________

Parent/Guardian Name: _____________________________ Phone: ____________Grade:__________

The Education Code defines certain requirements for the administration of medication in the school setting, including field trips and after school programs. A student can be allowed medication in the school setting if a Medication at School form has been completed and signed by parent and physician. At the beginning of each school year, or upon school entry, a Medication at School form must be completely renewed. If there is a change in the student's health status or medication regime, the parent must notify the school immediately and if applicable, submit an updated Medication at School form. Medication must be sent to school in the original pharmacy container and clearly labeled with student's name. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication. **No medications (including over the counter medications) will be given at school without a current prescription from your child's physician.**

PARENT'S REQUEST

We the undersigned, who are parents/guardians of the above named student, request that the school nurse or designated school personnel assist the pupil, when necessary, in the matter set forth by the physician's orders. We hereby consent to self-administration, if authorized by the physician. **Furthermore, we consent to appropriate school personnel consulting with the student's physician regarding the medication, if necessary.** In the event of an untoward or subsequent reaction or any other damages or injuries suffered or incurred as a result of the student's self-administration of medication, our/my signature below constitutes a full waiver, release and hold harmless of the district and school personnel from any and all civil liability related to such claims. **This authorization is good for one year from signature date.**

Date: _______________ Signature of Parent/Guardian: __________________________________

PHYSICIAN'S ORDERS

Medication/Dosage Prescribed	Dose	Scheduled Time to Administer	How to Give It Oral or Injection	Condition/Diagnosis or symptoms to look for

Authorization End Date: End of the School Year_________________Other:______________________

If Prescribing Asthma Inhalers/Auto-Injectable Epinephrine such as Epi-Pen/Glucagon:
Is the student authorized to carry prescribed asthma inhaler, Glucagon or Epi-pen on his/her person during school hours? Yes____ No____

I have instructed the student in the proper way to use his/her inhaler or epi-pen, including proper administration technique. It is my professional opinion that the student is able to self-administer the medication and should be allowed to carry and use the inhaler or epi-pen on campus.

Physician's Name (printed): ____Date: __________________

Physician's Signature: ____Phone: _________________

Parent Name (printed): ____Date: __________________

Parent's Signature: ____Phone: ________________

School Nurse: Patricia Gomes, RN

School Name: University High School Phone: (559) 278-8263 Fax: (559) 278-0447