SAN LUIS COASTAL UNIFIED SCHOOL DISTRICT
Division of Educational Services/Student Services Department

MEDICATION CONSENT FORM

Parents are requested to give medication at home and on a schedule other than during school hours. When it is necessary for prescription or over-the-counter medication to be given during school hours, written parent and health care provider authorization is required. This authorization is provided by the completion of both sides of this Medication Consent Form. The following procedures are required:

1. Parents shall sign the "parent/guardian authorization" below, which grants designated school personnel permission to administer **prescription or over-the-counter** medication.
2. Health care provider shall complete and sign the health care provider authorization (on the reverse side) for **prescription or over-the-counter** medication.
3. Prescription or over-the-counter medication shall be brought to the school by an adult in the **original container** with the appropriate label. Medication in baggies, envelopes, or other containers will not be accepted. (Upon request, pharmacists will divide the medication into two containers, one for school use and one for home use).
4. Instructions on the health care provider authorization form shall match those on the medication label. Parent may terminate the consent to administer medication via a written note only.
5. The school staff will not accept medication delivered by the student. The parent or a designated adult shall deliver the medication to the school site.
6. **A new consent form shall be completed each time there is a change in medication strength, dosage, or time. Parent may terminate the consent to administer medication via a written note only.**
7. For long-term medication, the consent form **MUST** be completed by the parent and health care provider each **new school year.**
8. A student may carry and self-administer medication **only** when the health care provider initials the appropriate section of the consent form. This privilege may be revoked if the student is known to misuse his medication and thus be of harm to himself or others.
9. All unused medications shall be picked up by the parent within 5 working days, or it will be destroyed per safety regulations.
10. Students attending summer school are covered by consent forms completed during the current school year. The parent is responsible for providing the medication and a **copy** of the authorization form as part of summer school registration.
11. Permission is granted to the school nurse to contact the health care provider if necessary.

PARENT/GUARDIAN AUTHORIZATION

I am the parent/guardian of _____
(Name of Student)

I request the San Luis Coastal Unified School District (SLCUSD) to assist my child in taking medication as stated in the health care provider authorization (reverse side of this document).

I agree to release and hold harmless the SLCUSD, its officers, agents, and employees, for any injury, illness, or death which might occur as a result of assisting with the administration of the medication in accordance with the health care provider's direction.

Print Name	Signature	Date
_____	_____	_____

See Reverse Side for Physician Authorization

HEALTH CARE PROVIDER AUTHORIZATION

Name of child (print):_____ Birth Date: _____

Name of medication (one medication per form):_____

Reason for medication (diagnosis):_____

Strength (mg, etc.):_____ Dosage (amount):_____

Time of day or frequency to be given at school: _____

For "as needed" (prn) medications, describe indications (symptoms) when to be used: _____

_____

Method of administration (oral, topical, eye drops, etc.) and directions:

_____

_____

Possible side effects of medication: _____

_____

SELF-MEDICATION

Student may carry and administer his own medication **ONLY** if ALL the items below are initialed by the physician/dentist:

- ☐ Medication is needed by student for immediate emergency condition (i.e. diabetes, asthma, anaphylaxis, migraines)
- ☐ It appears that the student is physically, mentally, and behaviorally capable to assume responsibility.
- ☐ Student has successfully demonstrated self-medication procedure to health care provider.

_____

Additional comments/directions: _____

_____

_____ _____ _____

Health Care Provider (Print) Signature Date

_____ _____

Telephone Number Fax Number

_____

Address

Rev 2/09

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