PACIFIC GROVE UNIFIED SCHOOL DISTRICT
MEDICATION CONSENT FORM
(For Prescribed and Over-the Counter Medication)
Directions on the Reverse Side

PARENT/GUARDIAN PERMISSION

I am the parent or guardian of (student): _____

I hereby request that a school district employee assist my child in taking medication in accordance with the following written statement of the physician. I understand that the medication will not be dispensed by a nurse. I agree to indemnify and hold harmless the Pacific Grove Unified School District, its officers, agents, and employees, for any injury and all liability, illness or death which may occur as a result of assisting with administration of the medication in accordance with the following physician's direction.

Date _____ Parent/Guardian Signature _____

PHYSICIAN'S STATEMENT AND DIRECTIONS

Name of Student: _____ Birthdate_____

School Year: _____Grade _____School _____

Reason for Medication: _____

NAME OF MEDICATION: **DOSAGE:** **TIME(S) TO BE GIVEN:**

_____

_____

_____

Method of Administration ( ) Tablets ( ) Liquid ( ) Inhaler ( ) Other: _____

Possible Side Effects: _____

Duration of Administration (i.e., 10 days, 1 month, current school year) _____
FROM _____TO _____

Other pertinent information: _____

_____

CHECK WHICH OPTION APPLIES AND IS RECOMMENDED BY PHYSICIAN:

____ Medication should be administered under adult supervision in the office.

____ There is a significant potential of an urgent need for this medication at unpredictable times, AND the child has shown to me the maturity, ability and knowledge to carry and self-administer this medication per my instructions.

Date _____ Physician's Signature _____

Please stamp or print physician's name, address, and telephone number: _____

_____

Reference: California Education Code 49423
PGUSD BOARD POLICY & REGULATION 5141.21

MEDICATION CONSENT FORM DIRECTIONS

When possible, parents are advised to give medication at home and on a schedule other than school hours. If it is necessary that a medication be given during school hours, the following regulations must be followed:

1. Medication must be prescribed/advised by a physician/dentist. THIS INCLUDES OVER THE COUNTER MEDICATION.

2. Medication must be brought to school in **original container labeled by a pharmacist.** This label is to include the name and telephone number of the pharmacy; the student's name; doctor's name; medication, strength, dosage and time(s) of day the medication is to be given. When you get prescriptions filled, you can ask the pharmacist to put them into two containers so you will have one for school and one for home use.

3. Medication instructions must be completed and coincide with pharmacy label. Parents must get and supply to the school a copy of the pharmacy information sheet on this particular medication when requested by the school.

4. Parent/guardian must sign this form, granting designated school personnel permission to administer medication, according to regulations set herein.

5. Prescribing physician must sign this form for all medication requests.

6. Permission granted by the parent/guardian to school designated school personnel to contact physician/dentist if necessary regarding this medication and its administration.

7. Each time a student administers medication by himself with permission, the student must notify the School Office as soon as practical thereafter.

8. **All authorizations expire at the end of the school year (June).**

9. At the end of the school year the parent or guardian must take any remaining medication home; medications not claimed at the end of the school year should be discarded as recommended by the local health officer and appropriate OSHA guidelines. (If the medication changes during the school year, the remaining medication will be given to the parent or guardian at the time of delivery of the new medication.)

PARENT AND PHYSICIAN PLEASE COMPLETE CONSENT FORM ON FRONT PAGE