

_____ **SCHOOL DISTRICT**

PARENTAL AUTHORIZATION TO ADMINISTER MEDICINE
(TO BE KEPT CONFIDENTIAL UPON COMPLETION)

NAME OF STUDENT: _____ Grade _____

DIAGNOSIS/ILLNESS: _____

MEDICATION: _____ DOSAGE: _____

FREQUENCY: _____ SPECIAL DIRECTIONS _____

POSSIBLE SIDE EFFECTS: _____

I certify that the above information regarding this Student is correct, and that administration of the medication to this Student is necessary.

(Signature of Prescribing Physician)

(Date)

(Phone)

(Address)

California Education Code Section 49480 requires the parent or legal guardian of any public school student to notify _____ School District (District) of any continuing medication regimen. This includes insulin given on a daily basis and in emergency situations. Insulin and syringes will be stored for use in the health office only, with a physician's form describing type, dosage and frequency.

The above-named student has been instructed in the proper use of _____, including safety to self and others. We the parents/guardian feel that our child is responsible for their personal care and we understand that the health office will be unaware of any problems unless our child reports to the health office or to the teacher with this information.

The undersigned hereby acknowledges that he/she knowingly and voluntarily assumes all risks of bodily injury to his/her child, and expressly acknowledges their intention, by executing this instrument, to exempt and relieve the District, its officers, agents, and employees, from any liability for personal injury, bodily injury, property damage or wrongful death that may arise out of or in any way be connected with the self-administration of the above medication. I have read the foregoing and have voluntarily signed this agreement. I am aware of the potential risks involved in allowing my child to self-administer and I am fully aware of the legal consequences of signing this instrument. I further acknowledge that the District does not provide medical coverage for my child.

I/We authorize the School Nurse or, in his/her absence, the Principal or other designated school personnel to administer the above medication as indicated. I/We understand and agree that the District, the School, the School Nurse, the Principal or other designated school personnel shall not be liable for any injury to the Student resulting from the administration of the above medication as authorized by my signature below. It is recommended that parents bring medication to the school office whenever possible. Medication will not be sent home with students.

(Signature of Parent/Guardian)

(Date)