



PARENT/PHYSICIAN RELEASE FOR MEDICATION IN SCHOOL

PLEASE NOTE: THIS FORM MUST BE COMPLETED EACH SCHOOL YEAR

I. POLICY GOVERNING THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL:

When it is necessary for scholars to take prescription or over the counter medication during school hours the following procedure shall be followed:

- 1. Medication cannot be administered by school personnel unless there are completed parent and physician request forms on file in the school office.
2. Form to administer medication will then be kept with the medication in the school office.
3. The medication must be sent to the school in the prescription bottle or original container.
4. Medicine, including aspirin, shall not be kept in lunch boxes, desks, or teacher's desk.

II. BASIC LEGAL PROVISION - California Education Code 49423 (1976)

Notwithstanding the provision of Section 49423, any pupil who is required to take during the regular school day medication prescribed for him by a physician may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken; and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

III. PARENT REQUEST

Last Name of Scholar First Name Birth Date Grade School

My child will need to take medication at school. It is to be given at (time) with the following special instructions:

In agreeing to have the school administer my child's medication, I voluntarily agree to release, discharge, and hold harmless John Adams Academy and its officers, agents, and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which causes my child's illness, injury, death, and damages of any nature in any way connected with the administration of my child's medication. I authorize John Adams Academy to communicate with the physician below regarding my child's medical condition and/or the medication prescribed for it. { Yes { No .

Parent/Guardian Signature Date
Address Home Phone Work/Cell Phone
Emergency Contact Phone

IV. PHYSICIAN'S REQUEST

Medication:
Dose form/strength (tablet, liquid, inhaler)
Reason for medication:
Dosage/Frequency or time to be given at school
Precautions or important side effects { None anticipated { Yes. Please describe
Special Storage Requirements
Additional information: { On the reverse side of this form { As an attachment

Medication:
Dose form/strength (tablet, liquid, inhaler)
Reason for medication:
Dosage/Frequency or time to be given at school
Precautions or important side effects { None anticipated { Yes. Please describe
Special Storage Requirements
Additional information: { On the reverse side of this form { As an attachment

Date: Physician's Signature

Scholar has been instructed on correct use and may carry and self-administer metered dose inhalers: { Yes { No

Physician must sign approval

PHYSICIAN'S NAME:
ADDRESS:
PHONE NUMBER:

PLEASE RETURN TO:
John Adams Academy
Fax to: El Dorado Hills Campus (916) 934-5302
Lincoln Campus (916) 644-3172
Roseville Campus (916) 888-1433

Nurse's Signature

Admin's Signature