Request to Administer Medication at School

(This page to be completed by the Parent/Guardian)

Dear Parent or Guardian:

We received information from you indicating that your child may need medication while at school. In an effort to ensure safety, we want to give you the following information which is in accordance with the California Education Code (Section 49423) and NUSD Board Policy (Section 5141.21).

Any student who is required to take, when the student is under the District's care, custody, or control, including while on field trips, sporting events, and other off-campus District-sponsored activities, **medication** prescribed for them by a licensed healthcare provider in California, may be assisted by the school nurse or other designated trained school personnel, or may carry and **self-administer** prescription auto-injectable epinephrine or asthma medication, **if the School District receives the appropriate written statements as follows:**

- ❏ Health Care Provider's order detailing the name of the **medication**, method (route), amount, and time schedules by which the **medication** is to be taken.
- ❏ Statement from the parent or guardian indicating the desire that the school district assist the pupil in the matters set forth in the statement of the Health Care Provider.
- ❏ Confirmation that the student is able to **self-administer** auto-injectable epinephrine or prescribed asthma medication as noted by the Health Care Provider.
- ❏ Consent from parent or guardian agreeing to the **self-administration**
- ❏ A release for the school nurse or other designated school personnel to consult with the health care provider of the pupil regarding any questions that may arise with regard to the **medication**
- ❏ A release for the school district and school personnel from civil liability if the **self-administering** pupil suffers an adverse reaction as a result of **self-administering medication**

I (We), the undersigned, who is the parent or legal guardian, request the medication be administered to my child when my child is under the District's care, custody, or control. I (We) acknowledge that a trained member of the NUSD school staff or the school nurse will administer the medication in accordance with the physician's orders. I (We) will notify the school immediately if there is a change of physicians or if the medication is changed.

I (We) acknowledge that it is the responsibility of the parent/guardian to enable district employees to administer or otherwise assist the student in the administration of medication by providing a written statement from the physician and ensuring that the medication is delivered to the school in a proper container by an individual legally authorized to be in possession of the medication.

I (We) authorize the NUSD school nurse or other designated school personnel to consult with the health care provider of my student regarding any questions that may arise with regard to the **medication. My (Our) signature on this form also serves to** release the school district and school personnel from civil liability if my student suffers an adverse reaction as a result of **self-administering medication.**

I (We) acknowledge that the parent/guardian may terminate consent for such administration at any time.

The written statements specified above shall be provided at least annually and more frequently if the **medication**, dosage, frequency of **administration**, or reason for **administration** changes.

Student Name:_____ Date of Birth:_____

Parent/Guardian Name & Phone (Print)_____

Parent/Guardian Signature:_____ Date:_____