San Francisco Unified School District – School Health Programs, SFCSD

MEDICATION FORM (One Medication per Form)

Dear Parent/Guardian/Caregiver:

California Education Code 49423 provides that students required to take medically prescribed or over-the-counter medications during the school day **MAY** be assisted by school personnel **ONLY** if the school district receives a specific written statement from the health care provider **AND** the parent/guardian/caregiver of the student. **Please complete this entire form and return it to the Principal.**

IF POSSIBLE, PLEASE SCHEDULE MEDICATION OUTSIDE OF SCHOOL HOURS

P l e a s e p r i n t l e g i b l y i n a l l s e c t i o n s

Student Name: Last	First	Middle	Date of Birth (Month/Day/Year)

HEALTH CARE PROVIDER SECTION

Health Condition for which medication is prescribed:	Medication: Dose: Frequency:_____Duration:_____	
How is medication to be given? ❒ By mouth ❒ Inhalation ❒ Injection ❒ Topical ❒ Other:_____	Time medication needs to be given at school? _____AM / PM	
The medication is to be continued as above until: (please be as specific as possible about date)	Any precautions that school personnel need to know? Contraindications?	
What are possible reactions/side effects?	What should be done in the event of reaction/side effect?	
Check appropriate boxes below: ❒ I authorize this student to **self-administer** the above medication. ❒ I authorize designated school personnel to administer the above medication.		
Print name, address & phone number of Health Care Provider	Signature of Health Care Provider	Date:

PARENT / GUARDIAN / CAREGIVER SECTION

Parent/Guardian/Caregiver Name			Home Language	Daytime Phone ( )
Address – Number and Street	Apt No.	City	Zip Code	Evening Phone ( )
School Children's Center / Elementary / Middle / High				School Hours
Check appropriate boxes below: ❒ I permit my child to give himself/herself the above medication. ❒ I permit designated school personnel to give my child the above medication.				

1. I agree to hold the San Francisco Unified School District (SFUSD) and its employees harmless from any and all liability for the results of taking the medication or the manner in which the medication is given.
2. I will reimburse the SFUSD and its employees for any liability arising out of these arrangements.
3. I will notify the Principal of the school immediately if there is a change in my child's medication.
4. I understand it is my responsibility to send the medication to school in the **original pharmacy container** labeled with my child's name and the health care provider's instructions.
5. I understand how district employees will administer the medication or otherwise assist the student in its administration
6. I understand that this form automatically expires at the end of each school year.
7. **I give my consent for school authorities to take appropriate action for the safety and welfare of my child.**
8. I grant permission for an authorized district representative to communicate directly with my child's authorized health care provider and/or pharmacist, as may be necessary, regarding the health care provider's written statement or any other questions that may arise with regard to the medication.

Parent/Guardian/CaregiverSignature:_____Date: _____