Turlock Unified School District

# REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

*Please fax or return form to the School Health Office.*

Student: _____ Birth Date _____ Male ☐ Female ☐

School: _____ Teacher: _____ Grade _____

School FAX: _____ School Phone: _____

## TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER

*(Make copies if more than one medication is required.)*

**Medication Name:** _____ Strength (mg, ml, mcg): _____

**Dose (3 of tab, puffs, etc.):** _____ Method of Administration _____

**Time of Administration:** _____

**Start:** Immediately_____ Other Date_____ Stop_____ End of Year_____ Other Date/Duration_____

**PRN** (prescribed as needed)**:** Symptoms _____

**Reason for Medication:** _____

**Restrictions and/or important side effects:** ____None Anticipated _____Yes, please describe _____

### REQUEST FOR SELF-ADMINISTRATION OF INHALER AND EPI-PENS
### *AND/OR ANY OTHER HEALTH RELATED MEDICATION(S)*

This student is both capable and responsible for self-administering auto-injectable epinephrine, inhaled asthma medication and/or any other health related medications:

_____Yes, unsupervised. _____Yes, supervised. _____No, please indicate additional information: _____

Health Care Provider's Name: _____

Health Care Provider's Signature: _____ Date: _____

Fax#: _____ Phone#: _____

## TO BE COMPLETED BY PARENT OR GUARDIAN

### PARENT/GUARDIAN CONSENT FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

Parent(s) guardian(s) of _____ request that medication be administered by the school nurse or a member of the school staff if the school nurse is not available. I consent to allow disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel. I will notify the school if the medication has changed or is no longer needed. Medication will be furnished in its pharmacy-labeled container.

**Parent/Guardian signature:** _____ **Date:** _____ **Phone#:** _____

### PARENT/GUARDIAN CONSENT FOR SELF-ADMINISTRATION OF MEDICATION

**FOR AUTO-INJECTABLE EPINEPHRINE OR INHALED ASTHMA MEDICATION OR OTHER HEALTH RELATED MEDICATIONS**

I hereby consent for my child, _____, to self-administer the following medication during the regular school day or when attending school-related activities: ☐ Auto-injectable epinephrine ☐ Inhaled asthma medication

I also consent to disclose identifiable health information by the health care provider to the school nurse or other personnel designated by Turlock Unified School District

I acknowledge that I have an obligation to notify the school if my child's medication, dosage, frequency of administration or reason for administration changes during the school year.

I, on behalf of myself, my child, our heirs, executors and assigns, hereby agree to indemnify and hold harmless, release and covenant not to sue the District, it's officers, employees, and agents, for any and all liability, claim or cause of action of any nature whatsoever, including but not limited to personal injury or death, which may result from my child's self-administration of medication

**Parent/Guardian Signature** _____ **Date:** _____ **Phone#:** _____