**Natomas Unified School District**  
 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, during the regular school day, **medication** prescribed for him or her by a physician or surgeon, 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:

❑ Physician’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, foster parent, or guardian indicating the desire that the school district assist the pupil in the matters set forth in the statement of the physician.

❑ Confirmation that the student is able to self-administer auto-injectable epinephrine or prescribed asthma medication as noted by the physician

❑ Consent from parent, foster 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 during the regular school day. 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: DOB:

Parent/Guardian Name & Phone (Print):

Parent/Guardian Signature:

**Natomas Unified School District**

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***(This page to be completed by the Student’s Physician)***

Medication may be given to children and youth by school personnel, whenever physicians find it necessary to prescribe medication during school hours. School personnel will of course cooperate with parents in this regard by providing a safe place for the medication to be stored, etc., however, the major responsibility for a child taking medication at school rests entirely with the child’s parents.

In accordance with the California Education Code (Section 49423) and NUSD Board Policy (Section 5141.21), the following information must be given by the student’s physician in order for medications to be administered to the student during the regular school day:

Student’s Name: DOB:

Name of Medication:

Method (Route) of administration: Times for administration:

Amount (Dose) to be administered:

Possible Side Effects

If the physician is prescribing an auto-injectable epinephrine or asthma medication, is this student competent and trained to self-administer the medication? ❑ Yes ❑ No

Should the student be permitted to carry the auto-injectable epinephrine or asthma medication on his/her person? ❑ Yes ❑ No

Physician/Health Care Provider Name (Print):

Physician/Health Care Provider Signature: Date:

Address:

Telephone #: Fax #:

**Physician’s Stamp (Required)**