P.O. Box 213030
Stockton, CA 95213-9030
(209) 468-5940

PRESCRIBED MEDICATIONS ADMINISTERED IN SCHOOL

*Student's Last Name, First Name _____ *Date of Birth _____

*School/Academy/Teacher of Record/Grade _____ *Allergies _____

PARENTAL CONSENT FOR ASSISTANCE WITH MEDICATION ADMINISTERED BY SCHOOL PERSONNEL
TO BE COMPLETED BY PARENT OR GUARDIAN

Parent or Guardian Consent: I request Venture Academy Family of Schools (VAFs) school nurse or other unlicensed designated school personnel to assist my child by administering the medication as prescribed below by the physician. My signature confirms that this medication is required to be given during the school day as it is an emergency medication, given for specific health reasons, and/or otherwise would require my child to remain home. My signature on this form gives VAFs permission to speak to my child's physician about the medical condition(s) treated by the medication(s) listed below. **I acknowledge this prescription is valid for one year (Ed Code § 49423).**

I understand that it is my responsibility: *California Education Code #33308.5, 49400 and 49423 (CA Dept. of Education Program Advisory on Medication Administration, May, 2005)*

- To have my child's physician complete this form and acknowledge that it must be returned to the school nurse with the medication before any medication can be given.
- Ensure the medication is in the original container with a pharmacy label that includes my child's name, prescribing physician's name, date, diagnosis, medication name, dosage, time(s), and special directions for use. Over-the-counter medication must be in original, unopened container with my child's name on it. Parent/Guardian must provide all medication, related equipment, and supplies to administer it. Students may not transport medication, only parents/guardians may do so, with the exception of students who are allowed to carry their medication on their person at all times. Parent/Guardian must also pick up discontinued medication and/or at end of school year. Failure to do so will result in the disposal of abandoned medications according to state and local laws.
- To notify the school nurse of any changes in medication, dosage, frequency, time(s), reason for administration, health status change, or healthcare provider. Parent/Guardian must provide written documentation of these changes, which must include a new order form, parent written consent, and updated pharmacy label/container.
- Provide written notification of request to discontinue a medication. Any request to re-start medication will require a new written authorization from physician and parent.
- I, on behalf of myself, my child, our heirs, executors, and assigns, hereby agree to hold harmless, release, and covenant not to sue the San Joaquin County Office of Education (Venture Academy), its 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 from missed or refused doses or by side effects resulting from the medication(s), which may result from the district's assistance to administer the medication or from my child's self-administration of medication.

_____

* Parent/Guardian Signature * Parent/Guardian Printed Name *Date *Phone Number

***I hereby consent and acknowledge that my child may safely self-administer the following medications independently.** ☐ **Yes** ☐ **No**

PHYSICIAN'S WRITTEN AUTHORIZATION
TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER

Physician's Consent: Dear Doctor, per California Education Code #33308.5, 49400 and 49423, we are in need of the following information to authorize the nurse and/or other unlicensed designated school personnel to dispense prescribed medication at school, including over the counter medications:

***Medication is required to be given during the school day?** ☐ **Yes** ☐ **No**

***This child may self-administer the following medication(s)?** ☐ **Yes** ☐ **No**

This order to remain in effect for one year, until orders change, or until: End of School Year

	Medication	Dose	Time	Route	*Diagnosis	S/S for PRN Med	Possible Side Effects
School Medication #1							
School Medication #2							
School Medication #3							

_____

*Physician's Printed Name *NPI Number *Address *City/State/Zip *Phone

_____

*Physician's Signature ***(NP must include furnishing#; PA must include supervising physician information)*** *Date

***REQUIRED INFORMATION:** Failure to complete all areas will delay implementation of orders until all information is received in writing. Any change in medication, dosage, or time must be authorized in writing by the physician and given to school personnel (school nurse).*