Please fill out this form only if your child must take medication during the school day.

For all medication needed at school, including over-the-counter medication and/or supplements, district policy and state law requires: **1)** A medication form must be filled out by both parent and doctor; **2)** An adult must bring the medication to the office in its pharmacy/original container; **3)** Medication must be administered at the school office. However, a student may carry emergency medication with written permission of the doctor and approval of the health professional at your child's school. For River Elementary, contact Amy Bales, LVN. For Tularcitos Elementary and Captain Cooper Elementary, contact Melanie Allen, RN. For secondary schools, contact Susan Pierszalowski, RN.

CUSD #304 **CARMEL UNIFIED SCHOOL DISTRICT** E 5141.21
Updated 3/4/13

REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION

NOTE: **This request must be renewed each year. If the medication program is changed, a new request form must be submitted.**

Student Information:

Name of Student: _____ Date of Birth: _____ School: _____

Parent Request: I hereby request that a member of the school staff designated by the Principal assist in administering medication to my child. I have read and agree to the conditions described on the reverse side of this form.

X_____ _____
Signature of Parent/Guardian Date

Parent Consent to Exchange Information: In recognition of the importance of effective monitoring of the medication being administered, I give consent for Carmel Unified School District to exchange information with the physician,

Dr. _____ Phone: _____

X_____ _____
Signature of Parent/Guardian Date

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PHYSICIAN AUTHORIZATION

(To be completed by the medical provider for all medication)

Name of Medication_____

Dose_____ **Route** _____

Time(s) to be taken at school_____ **Interval between doses.**_____

Purpose of medication _____

To be given until (date)_____

Comments _____

FOR ASTHMA ONLY:

Asthma Symptoms Are Triggered By (Check all that apply):

___Exercise ___Dust Mites ___Animal Dander
___Cold Weather ___Strong odors or fumes ___Pollens
___Respiratory Infection ___Molds ___Other:_____
___Foods (list):_____

Inhaler Use (check all that apply):

___Before exercise or exertion ___With a spacer ___Closed mouth technique
___ **It is my professional opinion that this student should be allowed to carry and use the above named inhaler by him/herself.**

X_____ _____
Signature of Physician (required) **Date**

For Office Only: Send copy to Health Specialist

CONDITION OF AGREEMENT

In return for valuable consideration in the form of administering of medication, we do hereby absolve and release the Carmel Unified School District, its officers, employees and agents from any and all liability which might arise by reason of such administering of medication, and we do hereby covenant and agree not to initiate any suit or action of law or otherwise against the Carmel Unified School District, its officers, employees and agents, not to prosecute or file or to assist in the prosecution of filing of any claim or compensation, on account of any damage, loss or injury to our child as a consequence of the administering of medication prescribed by said physician.

It is understood that the Carmel Unified School District is undertaking this action solely to assist and advance our child's welfare and only because the said physician has requested such action on the part of the school district in behalf of our child. We agree to supply the medication directly to the appointed school employee. The medication will be in a properly labeled pharmacy container with the name and telephone number of the pharmacy, the student's identification, name of the physician, and dosage of the medication to be given.

Any change in these arrangements must be secured by filling out a newly dated copy of this form.