Bakersfield City School District

# Medication Administration Form

This form must be completed before any medication (prescription or over-the-counter) can be given or taken at school. Signatures are required from the parent/guardian and an authorized health care provider who is licensed in the State of California to prescribe medication. For additional information, you may request a copy of California Education Code 49423. **NOTE: This form must be renewed yearly, or sooner if there are any changes to the medication, dosage, frequency of administration, or reason for administration.**

| **Student Name:** | **Date of Birth:** |
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| **School:** | **School Year:** |

## THIS SECTION TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

| **Health Condition For Which Medication Is Prescribed:** | **Medication Name (generic/brand):** |
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| **Dose:** (if liquid medication, need dose and concentration) | **Route:** |
| ❑ **Daily**<br>Time to be given: | ❑ **As Needed (prn)**<br>Frequency:<br>For what symptoms: |
| **Side Effects:** | **Refer for medical evaluation if:** |

| ❑ **Permission To Carry And Self-Administer Emergency Medication**<br>I have instructed the above named student on the proper use of this medication, including how to appropriately self-administer, the correct dose, when to use, and the frequency. The student is able to safely and competently carry and self-administer this medication.<br>_____**(Health Care Provider Initials)** | ❑ **School Nurse, or other trained unlicensed school personnel, must administer. Store medication in a locked cabinet.**<br>❑ **Permission to carry medication to and from school** |
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| **Health Care Provider Signature:** | **Date:** |
| **Health Care Provider Name:** | **Phone:** |
| **Address:** | **National Provider Identification (NPI) Number, if applicable:** |
| **Name and Phone Number of Supervising Physician (PA's only):** | **Furnishing Number (NP's only):** |

## THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN

By signing, I give consent for the school nurse, or other trained unlicensed school personnel, to assist my child with administering the medication listed above during school hours and during school sponsored activities. I understand that school staff will not be responsible for making this medication available during district or school "family events" since students would be attending these events with their families. I give consent for the school nurse to communicate with the health care provider and/or pharmacist regarding the medication listed above, as well as the health condition for which the medication is being given. I understand that it is my responsibility to provide the medication, supplies, and equipment that my child needs in order for the school to provide the requested assistance to my child. I understand that the medication must be furnished by me in the original pharmacy-labeled container (or original sealed packaging if the medication is over-the-counter). I understand that school personnel will follow the health care provider's written statement above and that I cannot make changes or modifications to the medication administration directions given by the authorized health care provider. I understand that it is my responsibility to notify the school nurse, or other designated school personnel, if there is a change in my child's medication or health condition. I understand that all medication orders will be automatically discontinued yearly.

| **Parent/Guardian Signature:** | **Date:** |
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**Parent/Guardian Permission to Carry and Self-Administer Emergency Medication**
By signing, I give consent for my child to carry and self-administer the above listed emergency medication. I understand that it is my responsibility to ensure that my child brings their medication to school and any school sponsored activities. I understand that if my child uses the medication in a manner other than as prescribed, does not store the medication in a safe and secure place when not in use, or shares the medication with another student, my child will lose their privilege of carrying and self-administering this medication. In addition, disciplinary action may be taken. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administration of this medication.

| **Parent/Guardian Signature** | **Date** |
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