NORRIS
SCHOOL DISTRICT

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Dear Parents,

The Norris School District recognizes that certain students may need to take medication during school hours. Any student who is required to take medication may be assisted by the school nurse or other designated school personnel if the school district receives the two following items:

1. A written statement from the prescribing physician detailing the method, amount, and time schedules by which such medication is to be taken, including the doctor's signature and physician's stamp.

2. A written statement from the parent or guardian of the student indicating the desire that the school district assist the student in the matters set forth in the physician's statement.

Medication is not to be kept by any student, except in certain circumstances deemed necessary by the supervising physician. Medication includes both prescription, and over the counter substances. Parents/guardians must deliver the medication in its originally received container with all labeling intact, and a prescription label attached to ALL medication(s) including over the counter medications. A medication authorization form is needed for all medications, please fill out the form completely, one form per medication.

All medications must be delivered to the school by the parent or guardian.

We hope your student has a wonderful school experience. We are committed to meeting the health and safety needs of each child. With your help, every child's school experience will be safe.

Thank you,

Norris School District Nurses

NORRIS SCHOOL DISTRICT

Physician's Authorization For Medication To Be Taken At School

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 to prescribe medicine in the state of California. For additional information, you may request a copy of California Education Code 49423.

This form must be renewed each school year, or sooner if there are any changes to the medication, dosage, frequency of administration, or reason for administration.

Student Name:	Birth Date:	Sex:
School Site:	Grade:	School Year:
List All Medications Routinely Taken **OUTSIDE** of School Hours:		

THIS SECTION TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Diagnosis For Which Medication Is Prescribed:

Medication Name:	**Dosage** *(e.g., milligrams, puffs, etc)***:**
☐ **Daily:** Time Given: _____ /☐Lunch	☐ **As Needed (PRN):** Frequency: For What Symptoms:

Method of Administration: ORAL:☐Liquid ☐Tablet ☐Inhaler **DROPS:**☐Eye R/L ☐Ear R/L ☐Nostril R/L **OTHER:**☐Topical **or** ☐_____

Precautions or Side Effects:

Storage and Handling *(select one)***:**

☐ School Nurse or other designated unlicensed school personnel must administer. Store medication in a locked cabinet, or as otherwise indicated.

☐ Permission to Carry and Self-Administer Emergency Medications (e.g., epinephrine and inhalers **ONLY**). 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. _____ **(Health Care Provider Initials for Self-Carry)**

Physician Signature:	Date:	Physician's Stamp
Name of Physician:	License Number:	
Address:	Telephone/Fax:	

THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN

I request and authorize the school nurse or designated school personnel to assist my child, _____, with medication as prescribed and described on this form by the health care provider. I give permission for release/exchange of confidential information related to use of the listed medications, between the school nurse and my child's health care provider.

I understand that I must:

- Notify the school nurse of any changes in medication, health status, or authorized health care provider, and will provide a new medication order form.
- Submit a written statement to withdraw my consent for administration of medication at school, if needed.
- Provide the medication in a pharmacy labeled container that includes the name of my child, health care provider's name, medication, dose, route, and administration time.
- Ensure the medication is delivered to the school by parent/legal guardian or other individual legally authorized to be in possession of the medication.
- Supply all necessary materials or equipment for medication administration (e.g., measuring cup, inhaler spacer)
- Provide a current authorization for medication to be kept on file. A new form must be on file each school year for each medication.

I understand that:

- All medication not picked up by an adult on the last day of school will be discarded, unless other arrangements are made.
- Expired medication will be discarded one week after its expiration date, if not picked up by an adult, unless other arrangements are made.

I acknowledge that the school is not legally obligated to administer medication to my child. I agree to hold the school district and its employees harmless from any liability related to the medication or its administration and to indemnify the school district and its employees for any liability arising from this agreement.

Parent or Legal Guardian Signature:_____ Date:_____ Phone:_____

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 (e.g., field trips). 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 the 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 or Legal Guardian Signature:_____ Date:_____ Phone:_____