Rocklin Unified School District

Health Services

www.RocklinUSD.org/Health

Educational Excellence

Medicine at School

Student Name	Birth Date	Grade
Student Address	Home Phone	Work Phone

Parent Consent and Authorization

I (we), the undersigned, the parent/guardian(s) of the above named pupil, request the following medication be administered to my (our) pupil in accordance with the California Education Code §49423.5 and Board Policy/Administrative Regulation. I will:

- Provide all medication, supplies, and equipment
- Notify the school nurse if there is a change in the pupil's health status or attending physician
- Notify the school nurse immediately and provide new consent for any changes in the doctor's orders
- I acknowledge that if my student carries and administers his/her own medication, it must be on his/her person in order to attend a field trip

I authorize the school to communicate with the Authorized Health Care provider when necessary in regards to this specific medication and medical condition.

Parent/Guardian Signature_____ Date_____

Health Care Provider Request for the Administration of Medicine by School Personnel

- Diagnosis_____
- Medication_____
- Dose_____
- Method of administration_____
- Time medication is to be given at school, (if appropriate, please provide a range, e.g., q.2-4 hours) _____
- Possible reaction or side effects of medication_____
- Possible side effects or reactions that need to be reported to the physician, e.g., allergic reaction and treatment _____

Authorized Consent for Medication Administration at School

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance to CA state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for the maximum of one (1) year. If changes are indicated, I will provide new written authorization, which may be faxed.

Physician Signature_____ Date_____
Address_____ Telephone_____
Principal Signature_____ Date_____
Nurse Signature_____ Date_____