# JAMESTOWN ELEMENTARY SCHOOL

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JAMESTOWN, CA 95327
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## REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Any pupil who is required to take medication prescribed by a licensed health care provider/physician may be assisted by a school nurse or other designated school personnel. This accommodation is provided only when the schedule of medication would otherwise require the pupil to remain home, when medication is needed for emergency situations, or for specific health reasons.

All medication administered at school must be provided to the school in the original container from the pharmacist, complete with a licensed health care provider or physician's directions on the container detailing the method, amount, and time schedule by which the medication is to be taken. Parent/Guardian must provide appropriate dosage measuring device, especially for liquid medication.

All information requested below is necessary when school personnel are to give medication to a pupil during school hours.

1. Student's full name: ______________________________
2. Prescription number: ______________________________
3. The name and telephone number of the pharmacy filling the prescription:
   ______________________________ Phone: ______________
4. The name and telephone number of the licensed health care provider/physician prescribing the medication:
   ______________________________ Phone: ______________
5. Name of medication and dosage: ______________________________
6. Time(s) of day medication is to be administered: ______________________________
7. Anticipated reactions, if any, to the medication: ______________________________

______________________________________________________________

My signature below verifies that:

1. I am the parent, care provider, or legal guardian of the pupil named above.
2. The medication I am requesting school personnel to administer is in the **original container** from the pharmacist or licensed health care provider/physician, complete with medication directions on the container.
3. I understand the school is not legally obligated to administer medication to any pupil and, therefore, I agree to hold the school district harmless from any and all liability resulting from the administration of the medication in the manner directed.

______________________________ ______________
Signature of Parent, Care Provider or Legal Guardian — Date

______________________________ ______________
Signature of Licensed Health Care Provider/Physician — Date

______________________________ ______________
Admin or School Designee — Date