Lakeside Union School District

14535 Old River Road, Bakersfield, California 93311
(661) 836-6658 FAX (661) 836-8059

□ **Lakeside School**
14535 Old River Road
831-3503 ✱ FAX 831-7709

□ **Suburu School**
7315 Harris Road
665-8190 ✱ FAX 665-8282

PUPIL MEDICATION TO BE ADMINISTERED AT SCHOOL
(This form is only valid for the school year)

TO PARENTS AND PHYSICIANS:

The following principles and procedures will be followed in the Lakeside Union School District when a parent requests that a student be permitted to take medication at school:

1. The administration of medication to pupils will be done only in exceptional circumstance wherein the child's health may be jeopardized without it and only when such administration has been requested and approved the student's parents and physician.

2. Pupils requiring medication during school hours (prescription or non-prescription), are to have the original container brought to the school office where it will be kept in a safe place and be administered as indicated on the container. *School personnel are only to keep the medication and in no way are to be responsible for seeing that it is taken*.

   PLEASE NOTE:

   a. Any time medication is administered at school it should be in a container with the pharmacist's label attached describing the kind of medication, the dosage, how often it should be taken, and the prescribing doctor's name. (Ed. Code 49423, 49480)
   b. Have your physician ask the pharmacist to prepare a separate container for the school to use. Some prescriptions can be divided so that the purchase of additional medication is not necessary.

3. A written statement will be required of:

   a. The family physician who shall indicate the necessity of said medication being given to the pupil during school hours.
   b. The parents, who shall request and authorize the designated school personnel to give said medication in the dosage prescribed by the physician.

4. <u>Under no circumstances are school personnel</u> to proved aspirin or any other patent medicine or nostrum to students unless prescribed by a physician.

5. **<u>IMPORTANT</u>**: All medicines administered at school should be brought to the school by the parents with this form signed by both parent/guardian and the physician. Please make sure that all portions of this form are completed.

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AUTHORIZATION TO ASSIST IN ADMINISTRATION OF MEDICATION

Physician's Statement

_____is under my care for _____ and I recommend that school personnel assist in the administration of the following prescribed medication:

Name of Medication:_____

Method of Administration: Tablet _____Liquid _____ Inhaler _____ Other _____

Dose _____Schedule of Doses _____

This medication is to be continued as above until: _____Precautions, possible reactions, and interventions:

_____

_____

For ASTHMA only: Is child authorized to self-medicate? Yes _____ No _____

Does child need to carry medication at all times? Yes _____ No _____

If medicine is to be given "AS NEEDED" describe indications and frequency of dosage:

_____

_____

Signature of Physician _____Date _____

Address _____Phone _____

Parent or Guardian Statement

As the parent(s) or guardian of the above-named pupil, we request the Lakeside Union School District to assist in carrying out the physician's instructions in the administrating of the prescribed medication during the school day.

We agree to notify our child's teacher and the school office immediately of any change in the medicine, dosage, and frequency recommended, and to sign a new statement when any differences occur from the above directions.

We agree to mutual sharing of information by our doctor and the school about our child's need for medication.

We understand that the school is not legally obligated to administer medication to any child and therefore agree to hold the school district and its employees harmless from any and all liability for the results of such medication or the manner in which it is administered, and to indemnify the school district and its employees for any liability arising out of this agreement. We agree that any time our child is to have his prescription medicine at school, it will be in a container with the pharmacist's label attached describing the kind of medication, the dosage, how often it should be taken, and the prescribing doctor's name.

Student's Name _____Birthdate _____Grade _____ Teacher _____

Date _____ Parent/Guardian's Signature _____

PLEASE RETURN THIS FORM TO THE SCHOOL OFFICE SIGNED BY THE PHYSICIAN AND THE PARENT OR GUARDIAN. NO MEDICATION WILL BE ADMINISTERED WITHOUT THESE REQUIRED SIGNATURES.

This form is valid for the remainder of this school year.