Liberty Union High School District

20 Oak Street
Brentwood, CA 94513
Phone: (925) 634-2166 Fax (925) 634-1687
Eric L. Volta, Superintendent

Dear Parent/Guardian:

The California Education Code has specific guidelines for all public schools regarding the administration of medication for both prescription and over the counter medications. Below is a summary of the requirements:

- A physician's statement must be completed each school year for students receiving medication during school and all school sponsored events. This form must be updated annually or if medication changes/dosages occur. Please see attached form.

- All prescription and over the counter medications must be delivered to school in its original labeled container. Medications not delivered in its original container will not be accepted by the school.

- All medication MUST be delivered to the school health clerk by an adult parent or guardian.

Please review, complete, and sign the attached form "Permission to Give Medication at School" and return it to school as soon as possible. If you have any questions or concerns, please feel free to contact me at (925) 963-1902.

Thank you,

Amy McClellan, R.N.
School District Nurse

An Equal Opportunity Employer

PERMISSION TO GIVE MEDICATION AT SCHOOL

Liberty Union High School District
California Education Code Section 49423 and 49423.5

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STUDENT'S LAST NAME FIRST MIDDLE AGE DATE OF BIRTH

TO BE COMPLETED BY THE PHYSICIAN

Name of Medication	Method	Dosage	Approximate Time of Day	Reason

SIDE EFFECTS: ____

PRECAUTIONS/SPECIAL DIRECTIONS: ____

IF PRN MEDICATION, LIST SYMPTOMS: ____

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Signature of MD or NP/PA & Supr. MD Lic.#/Furnishing # Address Phone

TO BE COMPLETED BY THE PARENT/GUARDIAN

My child is under the care of Dr. ______________________________. I understand it is my responsibility as the parent/guardian to keep the school supplied with and informed of any changes in my child's medication(s). I, or a designated adult, will bring the medication to the school in its original container or prescription bottle. I also understand it is my responsibility to monitor expiration dates of all prescription or over-the-counter medications I bring to school. I authorize the school nurse to communicate with the health care provider when necessary.

I give permission to ____ School to administer
(Name of school)

medication to my child, ____.
(Name of child)

Name of Parent/Guardian (print): ____

Signature of Parent/Guardian: ____

Home Phone: _____________________________ Work Phone: _____________________________

Date: ______________________________________

A new form is required every school year and if there are changes in the medication(s) or dosage(s).

**** Please pick up all medications from school site at the end of each school year. Medications not picked up will be discarded.***

Original: Cum File
Copy: Kept with medication

Rev. 12/2004