Kids Club
Pleasanton Unified School District

RE: PRESCRIPTION OR OVER THE COUNTER MEDICATION ADMINISTRATION CONSENT FORM

Dear Parent/Guardian:

Parents of students who require the administration of medication during the Kids Club day must a have a **PRESCRIPTION OR OVER THE COUNTER ADMINISTRATION CONSENT FORM** on file at your Kids Club site.

This form must be completely filled out annually and signed by the parent/guardian and the child's physician before the child can be assisted with the administration of medication by district personnel at Kids Club. The authorized health care provider must be licensed in California.

It is the parent/guardian's responsibility to provide the Kids Club with all necessary information and special instructions in writing related to the administration of medication to their child. The parent/guardian must immediately notify Kids Club in writing of any changes in the child's regimen or authorizing physician. It is also the child's responsibility to follow the health care provider's recommendations and instructions related to taking the medication.

In signing the **PRESCRIPTION OR OVER THE COUNTER MEDICATION ADMINISTRATION CONSENT FORM,** the parent/guardian agrees to release from liability the District, it's officers, employees and agents for any loss, damage injury or liability of any kind to any person caused or arising from the acts, omissions or negligence of the District, it's officers, employees and agents related to the administration of medication to their child.

Medication must be in its original container and brought to school by the parent/guardian. If you have any questions, please contact the Site Supervisor at your Kids Club Site.

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Pleasanton Unified School District

PRESCRIPTION OR OVER THE COUNTER MEDICATION CONSENT FORM

TO BE COMPLETED BY PARENT/GUARDIAN:

Student's Name _____ Date of Birth _____ ID# _____ Grade _____

Home Phone _____ Parent's Work/Cell Phone _____

This form must be completely filled out and signed annually by the child's parent/guardian and the child's authorized health care provider before the child can be assisted with the administration of medication by District personnel at any school site.

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Name of the Medication	Dosage	Method	Schedule or Time the Medication is Given

Purpose of the Medication _____ Duration _____

Special Instructions: (i.e. storage, restrictions, and important side effects) _____

Name of the Medication	Dosage	Method	Schedule or Time the Medication is Given

Purpose of the Medication _____ Duration _____

Special Instructions: (i.e. storage, restrictions, and important side effects) _____

Print Health Care Provider's Name _____ **Health Care Provider's Signature** _____ **Date** _____

Street Address _____ **Phone number** _____

City _____ **State and Zip Code** _____ **Fax number** _____

Pursuant to Education Code Section 49423, I authorize the teacher, principal, health clerk or other designated school personnel to administer medication to my child according to the prescription/dosage instructions listed above.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. To assume responsibility for getting my child's medication in its original prescription container to the school office/Kids Club.
2. To inform the school site personnel in writing of any important information or special instructions related to the administration of medication to my child.
3. To immediately inform the school site personnel of any change in my child's regimen or authorizing physician and I am willing to complete a new form.
4. To make certain that my child takes responsibility for taking the medication as prescribed.
5. If the medication needs to be broken (to give half the dosage), it must be broken at home by the parent. School staff will not take this responsibility.
6. To make certain prescriptions/medications are current.
7. To provide a release for the district nurse or other designated school personnel to consult with the prescribing health care provider and/or pharmacist regarding the medication.

I also agree that the District, its officers, employees and agents shall not be held liable for any loss, damage, injury or liability of any kind to any person caused or arising from acts, omissions or negligence of the District, its officers, employees and agents related to the administration of medication to my child. **I HAVE READ AND UNDERSTOOD THIS FORM AND CONSENT TO THE ABOVE PROVISIONS**

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Signature of Parent/Guardian/Authorized Representative Date

Form may be faxed to the Kids Club Administration Office by the physician. Kids Club fax number: 925-426-0564

Attention: Kids Club