Foothill Oaks Academy
Duarte, CA

REGULATIONS ON THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

RESPONSIBILITY OF PARENT/GUARDIAN:

1. Parents are encouraged to cooperate with the physician to develop a schedule so the necessity for taking medication at school is minimized.
2. Parents assume full responsibility for supplying medications. Request your pharmacy to prepare two (2) containers; one for home and one for school.
3. Medication must be labeled with child's name and be in original container.
4. Parents must deliver or have delivered by an adult, any medication taken during school hours. No medications may be brought to school by pupils.

RESPONSIBILITY OF PARENT/GUARDIAN:

1. A request form for EACH medication must be completed by the pupil's physician, with the following information: pupil name, name of medication, purpose, dosage, time precautions, special instructions, and possible adverse effects.
2. The container must be clearly labeled with the following: the pupil's name, physician's name, name of medication, dosage schedule, dose form, and date of expirations of prescription.

IT IS UNDERSTOOD THAT FOOTHILL OAKS ACADEMY IS NOT LEGALLY OBLIGATED TO ADMINISTER MEDICATION TO ANY CHILD, AND THEREFORE, I AGREE TO HOLD THE SCHOOL AND SCHOOL EMPLOYEES, FREE FROM ANY AND ALL RESPONSIBILITY FOR THE RESULTS OF SUCH MEDICATION OR THE MANNER IN WHICH IT IS ADMINISTERED AND TO INDEMNIFY EACH OF THEM AGAINST LOSS BY REASON OF ANY CIVIL JUDGEMENT ARISING OUT OF THESE ARRANGEMENTS WHICH MAY BE RENDERED AGAINST THEM.

I, the undersigned, who is the parent of ____ request that the medicine be administered to my child in accordance with his/her physician ______________________________________ M.D. by a member of the foothill Oaks Academy staff. I will provide written dosage instructions with the medication-prescription or over-the-counter. I will notify the school immediately if we change physicians or if this medication consent is to be changed.

____

Parent Signature/Date

This form must accompany ALL MEDICATIONS

Parent Permission for Medication Administration

Child Name:____ Date: __________

Day: _____________ **OR** From _________________ to _______________

Reason: ____

Name of medication: ____

Dosage: ______________________________________ @______________ o'clock.

Specific instructions: ____

____

Parent Signature: ____

Physician's Order: *To be completed if the medication is not labeled with the child's name, name of drug, physicians name and directions. (i.e., OTC medication)*

Time to be given: ____

Relevant side effects to be observed: ____________________________________

Other suggestions: _____________________________________

Length of time during which medication shall be given:

From _________________ to _______________

Physician's Signature: ____

Address: ____

Parent Signature: ____