**FREMONT UNIFIED SCHOOL DISTRICT**
**Fremont, California 94538**

# MEDICATION AT SCHOOL

To: Parent or Guardian and Attending Physician,

The California Education Code, Section 49423, and Fremont Unified School District A.R.5141.21 authorize the administration of medication to pupils **only** in exceptional circumstances wherein the child's health may be jeopardized without it and **only** when such administration has been requested and approved by the student's parent/guardian(s) and physician. These regulations apply to "over-the-counter" as well as prescription medication.

Parent/ guardian(s) must secure duplicate supplies of medication, one supply to be kept at home and one supply to be kept at school. The school supply must be in an original pharmacy-labeled container. The label shall contain the name and telephone number of the pharmacy; pupil's name; name of physician; and dosage, time and frequency of administration. Over-the-counter medications must be in the original manufacturer-labeled container. When the school supply of medication is depleted, additional medication must be brought to school in a new container, labeled as described above, with the most current prescription.

Medications under the jurisdiction of the Federal Controlled Substance Act (e.g. Ritalin and Phenobarbital) must be brought to school by an adult. All medications brought to school must be kept in a locked storage area.

In compliance with these regulations, we request that you provide the following information.

_____
Principal/School Nurse

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_____ _____
Student Name M/F Birth Date

_____ _____
School Grade/Room Date

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I hereby request that the school assist me with the administration of medication to my child during school hours and I give my consent to the school and doctor to exchange any information concerning my child.

Before my student can carry his / her medication, I understand that a) physician must give authorization, and b) my student and I must complete the FUSD self-administration of medication contract.

_____
Signature of Parent or Guardian

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**THIS SECTION MUST BE COMPLETED BY THE ATTENDING PHYSICIAN**

Student_____ Medical Record#_____

Medication_____

Specific Dosage Order_____

Time to be given at school_____

I authorize this student to carry on their person, and self-administer, the above prescribed: ☐ Asthma inhaler ☐ Epi Pen ☐ Other
I certify that I have instructed and trained this student to self-administer the prescribed medication and I will act as his/her supervisor.

The above medication cannot be scheduled for other than during school hours and such medication may be administered by designated, non-licensed school personnel.

Date_____ Physician's Signature_____
**(THIS FORM IS VALID ONLY FOR THE CURRENT SCHOOL YEAR, INCLUDING SUMMER SCHOOL)**

**Please stamp or print physicians name, address, and telephone number.**