

WASHINGTON UNIFIED SCHOOL DISTRICT
HEALTH SERVICES

MEDICATION IN SCHOOL

POLICY GOVERNING THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

WUSD Policy #5141.2.1 (1990)

The Board of Education recognizes that certain students may need to take prescribed medication during the school day. The school nurse or other persons designated by the Superintendent, shall assist such students in taking their medications in accordance with Ed. Code 49423.

II. BASIC LEGAL PROVISION – California Education Code, Section 49423 (1976)

Notwithstanding the provision of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken, and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

III. PARENT/GUARDIAN REQUEST

Student's Name _____ Birthdate _____
School _____ Grade _____

My child will need to take medication at school. The name and dose of this medication is:

I understand:

- a. The school nurse is not always available to give this medication and another staff member may be assigned to do so.
- b. I am required to personally bring the medication to school in the original container.
- c. The school district and its employees are not responsible for the results of this medication should any undue reaction occur and a civil action be brought against them.
- d. The major responsibility for a child taking medication rests with the child and his/her parents/guardians.

Parent/Guardian Signature _____ Date _____

Address _____ Phone _____

IV. PHYSICIAN INSTRUCTIONS

1. Medication, dosage, and method of administration _____
 - a. For emergency medication, is the student capable of self-administering the necessary treatment/medication? Yes _____ No _____
 - b. Will the student need to carry this medication on his/her person? Yes _____ No _____
 - c. Will the student need to self-administer this medication? Yes _____ No _____
2. Indication for Medication _____
3. Time Schedule _____ Duration _____
4. Special Instructions/Precautions/Possible Side Effects _____

Physician's Signature _____ Date _____

Name _____ Date _____

Address _____

PLEASE NOTE: THIS FORM MUST BE COMPLETED YEARLY