| STUDENT’S LAST NAME |  | FIRST |  | MIDDLE |  | AGE |  | BIRTH DATE (MM/DD/YY) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ACADEMY OR LEARNING CENTER |  | PRINCIPAL OR ACADEMY COORDINATOR |  | ADVISOR OR TEACHER |

**The California Education Code relating to the giving of medications at school states:**

 **49423**. Notwithstanding Section 49422, any pupil who is required to take, during the regular school day,

 medication prescribed for him or her by a physician or surgeon, may be assisted by the school

 nurse or other designated school personnel or may carry and self-administer prescription auto-injectable

 epinephrine if the school district receives 1) 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 matter

 set forth in the physician’s statement.

All JCS-Inc. Charter Schools have implemented the following procedure. The information requested on this form is necessary to comply with the law and to insure adequate protection for students.

**TO BE COMPLETED BY A LICENSED PHYSICIAN**

| **A.** | **Nature of the condition** requiring medication during the regular school day |
| --- | --- |
|  |  |
|  |  |
| **B.** | **NAME OF MEDICATION** | **METHOD OF ADMINISTRATION** | **DOSAGE** | **APPROXIMATE TIME OF DAY** |
|  | 1. |  |  |  |
|  | 2. |  |  |  |
| **C.** | **DISCONTINUE USE OF MEDICATION 1 ON :** |  | **DISCONTINUE USE OF MEDICATION 2 ON :** |  |
|  |  | Date |  | Date |
| **D.** | **Upon receipt of medication orders, the school personnel and physician shall consult as needed. Please note that a school nurse is not on staff at the school site. School personnel will not administer *non-emergency* injections.** |
| **E.** | Do you wish to talk briefly, by telephone, with school personnel at intervals to discuss the effect of medication? If so, indicate approximate interval: |
|  |  |
|  |  |  |  |  |  |
|  | **PRINT PHYSICIAN’S NAME** |  | **LICENSE NUMBER** |  | **PHONE** |
|  |  |  |  |  |  |  |  |
|  | **PHYSICIAN’S SIGNATURE** |  |  |  | **DATE** |  |  |
|  |  |  |  |  |  |  |  |
|  | I agree with the above: |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | **PARENT/GUARDIAN’S SIGNATURE** |  |  |  | **DATE** |  |  |

 **TO BE COMPLETED BY PARENT OR GUARDIAN**

1. Please have an **adult** deliver the medication and completed form to the school.
2. Medication must be in its original container, labeled with the student’s name, name of medication, dosage and include any necessary equipment for administration (e.g. spoon for liquid medication)
3. After the date for discontinuance of medication specified by the physician, changes to or continuance of the arrangements must be secured by filling out a newly dated copy of this form. All medication requests must be renewed each school year if continuation of the medication is necessary.
4. I understand that there is no school nurse on staff and I request that the coordinator or other designated personnel, administer the medication as directed by the physician on the front of this sheet. I understand that designated school personnel have my permission to communicate with the prescribing physician on matters related to this medication. I agree to save and hold the school, its officers, employees or agents, harmless from all liability, suits or claims, of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

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 **PARENT OR GUARDIAN’S SIGNATURE DATE**