CAPITAL CHRISTIAN SCHOOL
9470 Micron Avenue Sacramento, CA 95827
(916) 856-5611 Fax (916) 856-5960

RELEASE FOR THE ADMINISTRATION OF STUDENT MEDICATION:

School personnel will cooperate with parents when a physician *prescribes* medication to be taken during school hours and is required for the student's health. However, the primary responsibility for the student taking medication at school rests entirely with the student and the student's parents. Students in middle and high school need to be responsible to come to the nurse's office during the time their medication is due. The school nurse or other designated personnel may assist the student in taking medication provided that the parent has complied with the school's requirements. Medication can only be given between 8:00 AM & 3:00 PM, emergencies excepted.

ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER, NOT EXPIRED AND CORRECTLY PRESCRIBED (with pharmacy label) FOR THE INDICATED STUDENT ONLY. ALL MEDICATION MUST BE KEPT IN NURSE'S OFFICE UNLESS THE STUDENT HAS A SELF ADMINISTRATION CONTRACT* ON FILE IN THE NURSE'S OFFICE. THIS FORM IS GOOD FOR ONE MEDICATION AND FOR ONE STUDENT. Please submit additional forms for each medication, and each student. (*Middle High students may be allowed to carry certain emergency medications with them, but only after parent, physician and school nurse approval)

LONG TERM (longer than two weeks) PRESCRIPTION MEDICATION
Medication that must be given for longer than two weeks must be accompanied by this medication release form *signed by the prescribing physician*; or a written statement *from the prescribing physician* indicating the student's name, date, medication, dose, route, reason, and time(s) for which the medication is to be given.

SHORT TERM (1-14 days) PRESCRIPTION MEDICATION
Medication that must be given for less than two weeks must be accompanied by this medication release form; or a written statement from the parent indicating the student's name, start and discontinue dates, medication, dose, route, reason, and time(s) for which the medication is to be given.

OVER THE COUNTER MEDICATION: Over the counter medication will only be given when it is accompanied by the "Non-Prescriptive Over-the-Counter Medication Release" form *signed by the parent* indicating the student's name, date, medication, dose, route, reason, and time(s) for which the medication is to be given. NO EXCEPTIONS, PLEASE.

SELF-ADMINISTRATION OF MEDICATION: Only Students in MHS **may** be allowed to carry emergency medication. In order to do so, the parent and physician must also complete the SELF-ADMINISTRATION OF MEDICATION CONTRACT in addition to this form.

STUDENT ____ GRADE ___________________________

Please assist my child in taking the provided medication as indicated. The school nurse or designee has my permission to communicate with my child's physician, and may counsel with school personnel regarding the possible effects of the medication on my child. I will notify the school immediately if any change in the medication is necessary. I understand the medication will be discarded after two weeks of discontinued use.

____ ______________ ________________________

PARENT/GUARDIAN SIGNATURE **DATE** **DAY PHONE**

MEDICATION ___________________________________ DOSE ____________________________________

TIME ________ AM ________ PM or ______ ONLY AS NEEDED EVERY __________ HOURS

ROUTE: ☐ ORAL ☐ INHALE ☐ EYE (R L) ☐ EAR (R L) ☐ OTHER

REASON __________________________________ SIDE EFFECTS __ ______________________________

GIVE MEDICATION UNTIL: ______________________(date) OR ____________ UNTIL NOTIFIED

PHYSICIAN ____ **PHONE** ___________________________
Please print

PHYSICIAN'S SIGNATURE _________________________________ **DATE** ____________________