CAPITAL CHRISTIAN SCHOOL

9470 Micron Avenue Sacramento, CA 95827 (916) 856-5633

PARENT RELEASE FOR NON-PRESCRIPTIVE OVER-THE-COUNTER MEDICATION IN SCHOOL

PLEASE NOTE: THIS FORM MUST BE COMPLETED EACH SCHOOL YEAR FOR EACH MEDICATION and must be accompanied by the CCS "Release for the Administration of Student Medication" form.

Student's Name_____Date:_____Grade_____Teacher_____

My child will need to take non-prescriptive, over-the-counter medication. I understand that non-prescription medication shall be **brought to the school office in the original, sealed container(s) and labeled with my student's name and date of birth**.
ALL MEDICATION MUST BE KEPT IN THE NURSE'S OFFICE.

I, the undersigned, request that non-prescriptive, over-the-counter medicine be administered to said child by a designated member of the school staff in accordance with instructions outlined below.

I agree as soon as my child no longer needs to take this non-prescriptive, over-the-counter medication, I will personally retrieve the medication from the school office.

In agreeing to have the school administer my son's/daughter's over-the-counter medication, I voluntarily agree to release, discharge, and hold harmless Capital Christian School and its officers, agents and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which causes my child's illness, injury, death, and damages of any nature in any way connected with the administration of my child's medication.

I understand that the major responsibility for a child taking medication rests with the child and his/her parents/guardians, and that I am required to personally bring the medication to school(preschool through 6th grade). I understand that students in grades 7 through 12 may bring their own medication to the school office.

Please note: The School Nurse is not always available on the school site, therefore, over-the counter medications should be administered at home whenever possible. If over-the counter medication must be administered during school hours, please complete the information below:

Medication_____Dose_____

Time to give medication:_____ 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

Special Instructions_____

Parent/Guardian Signature_____

Home Phone_____ Work Phone_____ Cell Phone_____

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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 "Parent Release for Non-Prescriptive Over-the-Counter Medication in School" form *signed by the parent* indicating the students 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 _____ TEACHER _____

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 _____ 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*** _____

PHYSICIAN'S SIGNATURE _____ ***Date:*** _____