Atascadero Unified School District
5601 WEST MALL • ATASCADERO, CALIFORNIA 93422
DISTRICT OFFICE (805) 462-4200 • FAX (805) 462-4421

Parent Release for the Administration of Medication
Nursing Services FAX# 462-4413

_____ _____
Student's Name Date of Birth

_____ _____
School Allergies

Parent or Guardian Consent: I desire that AUSD staff administer the medication(s) as prescribed below by the physician. This form gives permission for AUSD staff to speak to my child's physician about the medical condition(s) treated by the medication(s) listed below. I understand that it is my responsibility to have my child's physician complete this form and that I must return it to the school before any medication can be given. I also understand that all medications must be sent in the original container marked with the student's name and indicate the type of medication and proper dosage. Students may not transport medication, unless consent to carry is on file, only parent/s or guardians.

_____ _____ _____
Parent/Guardian Printed Name Parent/Guardian Signature Date

Physician's Consent: Dear Doctor: In order to comply with the Education Code #49423, in regard to "Administration of Prescribed Medication for Student," we are in need of the following information for authorization for the school nurse or other designated school personnel to dispense prescribed medication at school, (including over the counter medications):

	Medication/Dose	Amount	Time	Route	signs/symptoms for PRN	Diagnosis
Medication #1						
Medication #2						
Medication #3						
Medication #4						

In order to administer medications safely at school and consider all possible side effects; please list or attach ALL medication this student takes; state "none" if no other medications except those prescribed above: _____
_____

_____
Physician's Printed Name Address City/State/Zip Phone

_____ _____
Physician's Signature Date

Any change in medications taken at school must be reported to your child's school immediately and a new medication form be completed and signed by your physician.

Revised 03/2018

Atascadero Unified School District
5601 WEST MALL • ATASCADERO, CALIFORNIA 93422
DISTRICT OFFICE (805) 462-4200 • FAX (805) 462-4421

AUTORIZACIÓN DE LOS PADRES PARA LA ADMINISTRACIÓN DE MEDICAMENTOS

(Parent Release for the Administration of Medication) FAX # 805-462-4413

_____ _____
Nombre del estudiante Fecha de nacimiento

_____ _____
Escuela Alegrias

Consentimiento del Padre o Tutor: Deseo que los empleados del Distrito Escolar Unificado de Atascadero (AUSD) administre las medicinas que el médico recetó como lo indico abajo. Este formulario concede permiso a los empleados de AUSD para hablar con el médico de mi hijo/a sobre las condiciones médicas tratadas por las medicinas anotados abajo. Entiendo que es mi responsabilidad de asegurar que el médico llene este formulario y lo entregue a la escuela antes de poderle dar cualquier medicamento a mi hijo/a. Además, entiendo que todas las medicinas deben ser enviadas en los botes originales y que la etiqueta tenga el nombre del estudiante e identifique el tipo de medicina con la dosificación apropiada. Los estudiantes no pueden andar con las medicinas en su posesión, a menos que haya un consentimiento por escrito en el archivo, solo los padres o tutores son permitidos.

_____ _____ _____
Nombre imprimido de padre o tutor Firma de padre o tutor Fecha

Physician's Consent/Consentimiento del Doctor: Dear Doctor: In order to comply with the Education Code #49423, in regard to "Administration of Prescribed Medication for Student," we are in need of the following information for authorization for the school nurse or other designated school personnel to dispense prescribed medication at school, (including over the counter medications):

	Medication/Dose	Amount	Time	Route	signs/symptoms for PRN	Diagnosis
Medication #1						
Medication #2						
Medication #3						
Medication #4						

In order to administer medications safely at school and consider all possible side effects; please list or attach ALL medication this student takes; state "none" if no other medications except those prescribed above: _____

_____

_____

Physician's Printed Name Address City/State/Zip Phone

_____ _____
Physician's Signature Date

Si ocurre algún cambio de medicamentos, necesita reportarlo a la escuela de su hijo/a inmediatamente y su médico de atención debe llenar y firmar un nuevo formulario de medicamentos.

03/2018 cff