(Only complete when student needs to bring meds to school)

Medication Form

Dear Parent/Guardian/Caregiver:
California Education Code 49423 provides that students required to take medically prescribed or over-the-counter medications during the school day **MAY** be assisted by school personnel **ONLY** if Gateway Public Schools receives a specific written statement from the health care provider **AND** the parent/guardian/caregiver of the student. **Please complete this entire form and return it to the main office.** **If Possible, Please Schedule Medication Outside of School Hours**

Student Name: Date of Birth:

----------Heath Care Provider Section----------

Health Condition for which medication is prescribed:

Medication: Dose: Frequency:

How is the medication to be given? (Please check one.)
[ ] By Mouth [ ] Inhalation [ ] Injection [ ] Topical [ ] Other:
About what time does the medication need to be given at school? AM / PM

What are the possible reactions/side effects?

What should be done in the event of reaction/side effect?

Check the appropriate boxes below:
[ ] I authorize this student to **self-administer** the above medication
[ ] I authorize designated school personnel to administer the above medication

Print name, address & phone number of Health Care Provider Signature of Health Care Provider

----------Parent/Guardian/Caregiver Section----------

Parent/Guardian/Caregiver Name: Home Language: Day Phone:

Address- Number & Street: Apt: City: Zip Code: Evening Phone:

Check the appropriate boxes below:
[ ] I permit my child to give himself/herself the above medication
[ ] I permit designated school personnel to give my child the above medication

1. I agree to hold Gateway Public Schools (GPS) and it's employees harmless from any and all liability for the medication or the manner in which the medication is given.
2. I will reimburse GPS and it's employees for any liability arising out of these arrangements
3. I will notify the Principal of the school immediately if there is a change in my child's medication.
4. I understand it is my responsibility to send the medication to school in the **original pharmacy container** labeled with my child's name and the health care provider's instructions.
5. I understand that this form automatically expires at the end of each school year.
6. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

Parent/Guardian Signature: ***Date:***