Tamalpais Union High School District ~ 2018-2019 School Year

AUTHORIZATION TO ADMINISTER MEDICATION/TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION TO PHYSICIAN

Student: ___________________________ Phone: __________________ Date: _______________

Grade ____ Physician __________________________ Physician's Phone __________________

1. MEDICATIONS

Medication	Dose	Time	Duration	Common Side Effects
______________________	____	____	_______	_____________________________________
______________________	____	____	_______	_____________________________________
______________________	____	____	_______	_____________________________________

2. Additional information and or precautions regarding medication or student's condition:

____
____

3. Authorization for Self-Administration of Medication.

Is the student authorized to self-administer one or all of these medications while at school?
Yes ___ No ___

If yes, please complete the contract below.

CONTRACT FOR SELF-ADMINISTERING MEDICATION AT SCHOOL

_________________ *(student's name)* has been instructed in the proper dosage and administration of
____ (*medication(s))*

We, (I) ______________________ *(Name of Parent or Guardian)* and ___________________________
(Name of physician) request that ________________________ *(Name of student)* be permitted to carry his/her medication on his/her person and self-administer it as directed by our physician, and in compliance with District policy and procedures.

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I _____________________, am the Parent or Guardian of the above student, and have lawful custody of said child. I hereby give consent to appropriate district personnel to administer or assist in administering, or allow my child to self-administer, medication and/or treatment as specified by Dr.______________________, named above. I hereby give consent to the district to receive from or send to Dr. ___________________any information concerning my child's medical condition.

Signed by Parent or Guardian ____, ________*(date)*

I am a PHYSICIAN actively licensed by the State of California and I authorize the above specified medication/treatment.
____M.D. _____________ *(date)*

____, Student ________________ *(date)*

PLEASE NOTE: It is the parents'/guardians' responsibility to see that this form is updated on a yearly basis or more often as needed should a child's medication/treatment change.