Millbrae Elementary School District
555 Richmond Drive
Millbrae, CA 94030
650-697-5693 ● 650-697-6865 (fax) ● www.millbraeschooldistrict.org

Revised Dec. 2021

PARENT/PHYSICIAN AUTHORIZATION AND RELEASE FOR THE SELF-ADMINISTRATION OF MEDICATION AT SCHOOL

Student/Child Name		Date of Birth	
Teacher/Grade			
School			

PHYSICIAN CERTIFICATION: To be completed by physician or other healthcare provider licensed by the State of California to prescribe medication.

Inhaler_____ EpiPen _____ Glucagon _____ Insulin _____ Other (diabetes related _____

Student/Child Name (PRINT)	
Diagnosis for which the medication is prescribed	
Medication Name	
Dosage	
Time	
Route	

If Dosage is as needed (PRN), the symptoms that necessitate administration and allowable frequency:	
Estimated Termination Date:	
Possible Side Effects:	

The student (named above) is under my care and needs to carry this medication with them while at school. I agree that the student named above is capable of self-administration and is able to manage this medication responsibly.

Date:	
Physician (Print):	
Address:	
Telephone Number:	
Physician Signature (Physician/Clinic Stamp):	

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PARENT CERTIFICATION:

California Education Code Section 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day, provided that appropriate authorization is given.

"Medication" includes prescription medication, over-the-counter- medication, nutritional supplements and herbal remedies. Parents are responsible for providing all medication and supplies and equipment necessary to administer the medication. No medications, including over-the-counter medications, will be given without a prescription. The medication prescription must be current and medication must be supplied in the original package or original prescription bottle with pharmacy label attached (ask your pharmacist to divide the medication into two bottles completely labeled: one for home and one for school). The medication must be prescribed to the student to whom it will be administered and all medication containers must include a label with the student 's name, physician's name, the name of the medication, and directions for use.

I authorize and hereby request that designated school personnel assist my child in taking this prescribed medication (including prescribed over-the-counter medication, nutritional supplements and herbal remedies) as prescribed by my child's health care provider. I agree to, and do hereby release and hold the Millbrae Elementary School District and its employees and contractors harmless from any and all claims, demands, causes of action, liability or loss of any type, because of or arising from acts or omissions with respect to this medication and agree to indemnify each of them with regard to any judgment or claim rendered against them arising out of this medication administration arrangement. I understand that my child may not have or take medication at school unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's health care provider and counsel school personnel as needed with regard to this medication.

I hereby give permission for my child to self-administer medication during the school day as prescribed by the child's physician. I understand that this authorization is in effect for a maximum of one (1) school year and the District will require a new authorization at the beginning of each school year, or immediately if any changes in prescription occur.

Parent/Guardian Name (Please Print)	
Parent/Guardian Address	
Parent/Guardian City, State Zip	
Cell Phone Number	
Home Telephone Number	
Work Telephone Number	
Email address	

Parent/Guardian Signature	X
Date	