CORNERSTONE CHRISTIAN SCHOOLS

ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Ed. Code 49423. "Any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by designated school personnel if the school has received: (1) a written statement from such physician detailing the method, amount and time schedule by which such medication is to be taken, and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school assist the pupil in matters set forth in the physician's statement." When the use of an inhaler, insulin injections or auto-injectable epinephrine is prescribed by a physician, the student may bring it to school when the following requirement has been met -- the physician must declare in writing that the student is proficient in the use of the inhaler and therefore, the student is entitled to administer the treatment in his/her self care in the presence of school staff. If your child needs to self administer these medications an additional form must be completed. This can be pick up in the school office.

PART I (To be completed by the parent or guardian)My child will need medication during the regular school day and I request that he/she be assisted by designated school personnel to follow the recommendation of our physician.

Name of Pupil _____ Birth date_____ Grade _____

Address _____ Telephone _____

Parent Signature _____

PART II I understand and agree to and do hereby hold Cornerstone Christian Schools and/or its employees harmless from any and all claims, demands, causes of action, liability or loss of any sort because of, or arising out of, the acts or omissions of the school or its employees with respect thereto.

Parent Signature_____

PART III (**To be completed by attending physician**) The child named above is under my care and it is necessary for him/her to receive the following medication during school hours on a regular/emergency basis.

[ ] O.K. for non-aspirin pain reliever for low fever or pain

Check here if accurate

_____ _____ _____

Medication Method of Administration Amount

Medical condition/diagnosis requiring medication _____

Reason for Medication _____

To be taken from _____ to _____

Date Date

Time schedule/Remarks/Possible side effects_____

_____

_____

_____ _____ _____

Physician's Name: Please Print Signature State License Number

_____

Address Telephone Date

ALL MEDICATION MUST BE ADEQUATELY LABELED AND PREPARED IN A CONTAINER BY A PHARMACIST OR PHYSICIAN AND BROUGHT TO THE SCHOOL OFFICE BY AN ADULT.