

FREMONT UNION HIGH SCHOOL DISTRICT
Authorization for Student to **CARRY** Medication in School
For School Year 2007-2008

TO BE COMPLETED BY PHYSICIAN

I certify that _____, **D.O.B.:** _____ **Grade:** _____
student's name

must carry _____ with him/her at all times
name of medication(s)

at school due to _____
medical condition(s)

OBSERVABLE ADVERSE REACTIONS THAT MIGHT BE SEEN AT SCHOOL: _____

____ This condition is such that there is inadequate time for the student to go to the office to obtain the medication.

____ I have instructed the student in the proper administration of this medication and have certified that he/she needs no adult supervision. I have further instructed the student in the dangers of giving the medication to anyone other than himself/herself. I have discussed the above stated risks and liabilities with the parent.

Physician's signature Date

Physician's address CA license number

Physician's name Phone

TO BE COMPLETED BY PARENT/GUARDIAN AND STUDENT

I permit my son/daughter to carry the above listed medication as ordered/approved by his/her physician or surgeon. I authorize the school nurse or other designated school personnel to consult with my child's health care provider regarding any questions that may arise with regard to the medication. My child's physician has fully instructed my son/daughter on the proper administration of this medication, and I certify that he/she does not need adult supervision. I accept responsibility for the appropriate use of this medication by my son/daughter. I am aware of the risks to my son/daughter and other students and assume responsibility for any liability related to the misuse of this medication. I agree to hold the school district and its employees free from any and all responsibility for such services or the manner in which it is administered.

Parent/Guardian's signature Date

Address

Home phone Work/Cellular phone

I have read and understand the medication information above. I will use my medication as I have been instructed and trained by my physician or surgeon. I will keep my medication on my person or in my possession at all times and I will not let anyone else handle or use my medication.

Student signature Date