Raising Indigenous Leaders for Pasadena & Beyond
h.m.
Luke 2:40
HARAMBEE MINISTRIES
www.harambeeministries.org
1609 Navarro Avenue, Pasadena, CA 91103

ADMINISTRATION OF MEDICATION FORM

Name of Student_____ Birth date_____
Address _____ Phone _____

☐ *Check here to opt out of having this form signed. In signing below, you release Harambee from any liability as it pertains to your child becoming sick. In the event your child gets sick, we will call you immediately.*
Print name: _____Signature:_____ Date: _____

TO THE PARENT OR GUARDIAN: To protect all children and to conform with the State Education Code (49423), no child may bring any medication (prescription or non prescription) to school. Only medication prescribed by a doctor may be given during school hours. If your child needs medication either for a few days or over an extended period of time and it must be given during school hours, you must have your physician complete this form. MEDICATION, whether prescription or non prescription, MUST ACCOMPANY this form and be delivered by a parent or guardian to the front office in the original labeled container. Only under these conditions may any medicine be given at school. Please note that this applies to non prescription drugs as well. Our office staff will not dispense over the counter pain medication (i.e. Tylenol or Advil), cough drops, etc., unless we are instructed by your physician in writing and this form is SIGNED BY BOTH PHYSICIAN AND PARENT

TO THE PHYSICIAN: Please complete and sign this form:
1) if medication prescribed for a school-aged child must be given during school hours to prevent serious physical or behavioral problems; or
2) if over-the-counter medicines such as Tylenol, Advil, cough drops, etc. are requested by parents to administer to their child during school hours. It is a request and guide to authorized school personnel to assist the pupil with the medication.

Name of Medication	Form	Purpose	Amt to be taken	Time of day
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Any special instruction, precautions or possible side effects: _____

How long will this medication be necessary? _____

This patient may carry their inhaler on them during the school day. __YES __NO __Not Applicable

Signature of Physician: _____ Date: _____

Print Name of Physician _____ Phone: _____

Address: _____

TO THE PARENT OR GUARDIAN: PLEASE SIGN THE FOLLOWING STATEMENT:

I request that the school assist my child in taking the prescribed medication as directed above and in accordance with the school policy.

SIGNATURE OF PARENT (MANDATORY): _____ Date _____