Safety Town Authorization to Administer Medication(s) and Release of Liability

Student Name:_____ DOB: _____ Grade:_____
Safety Town School Site: _____ Program dates: _____
To: Parent/Guardian and Physician
If a medication must be taken during the Safety Town program day, it is necessary in accordance with **California Education Code Section 49423**, to have a written statement on file. The statement must be signed by the parent/guardian and the physician indicating a desire that designated Safety Town personnel assist the student with medication administration. **The authorization must be made annually and/or whenever a change occurs.** Education Code requires that **ALL** medications, **prescription** and **over-the-counter** must have a completed statement from **BOTH** the physician **AND** parent/guardian **BEFORE** they can be administered. Medication must be provided in the **original container** labeled with the students name, medication name, dose/strength and **specific** administration directions.

Parent/Guardian Authorization

As the parent/guardian of the above named child, I request that designated Safety Town personnel assist in the administration of medication prescribed by the physician. I give consent for the physician and designated Safety Town personnel to communicate directly, regarding the administration of the medication. I understand it is my responsibility to bring all medication safely to the school and I agree to refill or replace medication as necessary. I understand that the medication will be stored in a locked area unless the physician indicates that my child is capable of carrying and self-administering it.

Parent/Guardian Signature: _____ Date: _____

Physician Authorization

As the physician of the above named child, it is, in my professional opinion appropriate and necessary that the following medication(s) be available for administration during the Safety Town program.

Please place an "X" through any unused columns.

Name of Medication(s)	**1.**	**2.**	**3.**
Purpose of Medication			
Strength/Dose			
Medication Form (liquid, tablet, inhaler, etc.)			
Route of administration (oral, inhaled, injected, etc.)			
Scheduled administration time(s) or frequency if PRN			
Duration of need (if other than entire week)			
Precautions, instructions, adverse effects or comments			
Can the student carry and self administer medication?	Please Circle **Yes / No**	Please Circle **Yes / No**	Please Circle **Yes/ No**

Physician Signature: _____ Date: _____

Print Physician's Name: _____ Phone: _____

Safety Town Waiver and Release

I, the parent/guardian of _____, (print child's full name), for myself and for my minor child, do hereby fully release and hold harmless Safety Town of Santa Barbara County, Goleta Union School District, any agent, director, officer, supervisor, or member of such organization from any and all liability, loss, damages, or injuries arising out of administering this medication during the SAFETY TOWN program in which I have enrolled my child.

I have read and fully understand this Safety Town Waiver and Release.

Parent Signature: _____ Date: _____