

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by a CA Licensed Health Care Provider)

Student name _____
Last First Sex Birth date School

Name of medication _____ Date of prescription _____

Dosage prescribed _____ Time schedule at school _____

Dose form _____ Route _____
(Tablet, liquid, injection, inhalant, etc.)

Purpose of medication or diagnosis _____

Licensed Health Care Provider's Recommendations (Check where applicable)

The medication may have adverse side effects (explain) _____

Special instructions and/or comments _____

The student for whom this medication is prescribed is under my care.

Print name/Title Signature Date

Address City State Zip code () _____
Telephone

Print name of Supervising Physician _____ (NP, Midwife, PA)

Furnishing Number _____ (NP/Midwife)

REQUEST FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

(To be completed by parent/guardian)

I request that my child _____, be assisted in using prescribed medication at school. I assume full responsibility for supplying all medication and shall deliver it, or have it delivered, to the school by another responsible adult, and agree to the District policies and procedures listed on the reverse side. I give my permission for the exchange of medical information regarding administration of medication at school with the authorized health care provider and pharmacist.

Date Signature of Parent/Guardian/Student 18 years Printed Name

() _____ () _____ () _____
Home telephone Work telephone Cellular telephone