LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Student's Last Name _____ First Name _____ Sex _____ Birth date _____ School _____

Name of Medication _____ Dose Form: (Tablet, Liquid, Injection, Inhalant, etc.) _____

Dosage Prescribed _____ Time/Frequency _____ Route (Mouth, Ear, Eye, Etc.) _____

Purpose of medication or diagnosis _____

LICENSED HEALTH CARE PROVIDER (To be completed by a Licensed Health Care Provider)

This student's medical condition requires immediate use of _____ (medication) and the student's well being is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

Please 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 of licensed health care provider _____ Signature _____ Date _____

Address _____ City _____ State _____ Zip Code _____ ( ) Telephone _____

Print name of Supervising Physician (if N.P., Midwife or P.A.) _____ Furnishing Number (if N.P. or Midwife) _____

PARENT/GUARDIAN

I request that my child, _____, be allowed to self-administer the medication at school. I assume full responsibility for supplying all medication and agree to the District policies and procedures listed on the reverse side. I request that the school comply with the orders of the above licensed health care provider.

I believe that my son/daughter is physically, mentally, and behaviorally capable of self-administering this medication. I hereby expressly waive and release the Los Angeles Unified School District from any and all rights or claims of any nature whatsoever I may have against the Los Angeles Unified School District, the Board of Education of the Los Angeles Unified School District, and its members, volunteers and employees, arising out of, in connection with, or resulting from the above request.

I give my permission for the exchange of medical information regarding self-administration of medication at school with the authorized health care provider and pharmacist.

Print name of parent or guardian _____ Signature _____ Date _____

( ) Telephone _____ ( ) Work telephone _____ Cellular telephone _____

SCHOOL PERSONNEL

I have received the request of the parent/guardian and orders of the above licensed health care provider and believe that the above student is physically, mentally, and behaviorally capable of self-administering this medication at school.

Signature of School Principal _____ Signature of School Nurse _____ Date _____

DISTRICT PROCEDURES REGARDING SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

1. Prescription medications must be clearly labeled by a U.S. dispensing pharmacy and contain the following information: (consistent with prescription of authorized licensed health care provider)

   - Student's full name
   - Physician's name
   - Dosage, schedule, route and dose form.
   - Date of expiration of the medication

2. Non-prescription (over the counter) medications that have been authorized by this request, must be in the original container.

3. Requests for Self-Administration of Medication during School Hours must be renewed annually.

4. Parent/Guardian will notify the school nurse or site administrator and provide a new Request for Self-Administration of Medication During School Hours when there is a change in the student's medication, health status or authorized health care provider.

5. Injectable medications, which are to be given on an emergency basis require special arrangements and training of school staff by the credentialed school nurse.

6. A copy of this authorization should be carried with the medication.