Lake Tahoe Unified School District

Parent/Guardian and Physician Request for Medication

Student Name	Birth date	School and Year	Grade

Address	Telephone	Teacher

PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NON-PRESCRIPTION

California Education CodeSection 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school; to maintain or improve his/her potential for education and learning.

I request that medication be administered to my child, _____ in accordance with our physician's written instructions. I understand that designated school personnel will administer medication under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing physician. I give permission to contact the physician when necessary.

_____ _____
Parent/Guardian Signature Date

_____ _____
Work Telephone Home Telephone

Emergency medicine such as EpiPen or inhalers may be carried by the student when authorized by a physician, parent and school nurse. A second EpiPen or inhaler should be kept at school for emergency use.

All medication must be in the student's original, labeled pharmacy container. The directors for administration on the school container must be in English. You may request additional containers from your pharmacist, one for the school and one for home, if needed.

PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION

Diagnosis/Reason for Medication: _____

Medication: _____ Dose:_____ Route: _____ Time: _____

If PRN: Amount of time between doses _____ Maximum number of doses per school day _____
Possible reactions: (possible serious reactions with this medication i.e., allergic reaction, localized/general, etc.)

_____

☐ Instructions for emergency care: _____

☐ **EMERGENCY MEDICATION SUCH AS AN INHALER or EPINEPRHINE AUTO INJECTOR MAY BE CARRIED BY STUDENT.**

The above medication cannot be scheduled for other than during school hours and this medication may be administered by non-medical school personnel under the supervision of a qualified School Nurse.

Physician Signature: _____

Telephone: _____

Date of Request: _____

Date to Discontinue Medication: _____ Office Stamp

THIS REQUEST IS VALID FOR THE CURRENT SCHOOL YEAR

SCHOOL USE ONLY:

Nurse: _____ Date: _____

Administrator: _____ Date: _____