



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 Code Section 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 directions 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: _____