Latrobe School District

Fax: 530-672-0463 Phone 530-677-0260

MEDICATION IN SCHOOL

Student Name: _____ Date of Birth: _____ Grade: _____

Request for Administration of Medication – Prescription and Non-Prescription

California Education Code 49423 allows designated school personnel to assist students who are required to take medication during the school day.

- I request medication(s) be administered to my student in accordance with our physician's written instructions including self-administration as approved by the physician.
- I understand that the school nurse is NOT on campus daily, and designated school personnel will administer medication under the supervision of a qualified School Nurse.
- I will ensure that the medication is delivered to the school in an original, labeled pharmacy container by myself or another responsible adult.
- I will notify the school immediately and submit a new form if there are any changes to this form.
- I grant permission for the school nurse or other designated staff to communicate directly with my student's physician or pharmacist for clarification and further information regarding medication(s).
- I give permission for the school nurse to discuss with school personnel my student's medication needs.
- I acknowledge I may terminate this consent at any time.
- I release the school district and school personnel from civil liability if the student suffers any adverse reaction by taking self-administered medication.

Parent/ Guardian Signature: _____ Date: _____

Physician's Request for Administration of Medication

Medication(S)	**Dose**	**Route**	**Time of Day** (Daily Meds)	**Frequency** (Prn Meds)	**Duration**	**Diagnosis**	**Possible Side Effects of Medication**

This student has been instructed about the proper use and need for this medication: ☐Yes ☐No

*This student may carry his/her medication and is competent to self-administer: ☐Yes ☐No

*This student may carry an epi-pen and is competent to self-administer this medication. ☐Yes ☐No

This medication may be administered by non-medical school personnel under the supervision of a qualified School Nurse.

Physician's Signature: _____

Date of Request: _____ Date to Discontinue: _____

Physician's Name (Print): _____

Phone: _____ Address: _____

THIS REQUEST IS VALID FOR A MAXIMUM OF ONE SCHOOL YEAR

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