

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
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