LAWNDALE ELEMENTARY SCHOOL DISTRICT

4161 West 147th Street · Lawndale, CA 90260 (310) 973-1300

Request for Assistance with Medication During Regular School Day

California State Law requires that all students who need medication during school hours must do the following:*

1. Present a written statement from the student's licensed physician detailing the method, amount and time schedules for the taking of the medication. (This includes over-the-counter medication)
2. Present a written statement from the student's parent/guardian requesting the District to assist the student in taking the prescribed medication.
3. Bring the medication in the original bottle, properly labeled.

Students may not carry medications on their persons or keep it in their lockers unless request in writing by the physician with approval from appropriate school personnel.

*Education Code 49423. Administrative Code Title 5. 18170

TO BE COMPLETED BY PARENT/GUARDIAN

Last Name of Student _____ First Name of Student _____ Sex _____ Date of Birth _____ School _____

I request that designated District personnel (not necessarily a school nurse) assist my child in taking the medication in accordance with the instructions provided below by the physician. I authorize the District to communicate with the physician below regarding my child's medical condition and/or the medication prescribed for it. I agree to hold the school district and its employee's harmless in providing this service to my child. As the parent/guardian, I will be responsible to re-supply medication promptly when empty or when medication has expired.

Date _____ Telephone _____ Signature of Parent/Guardian _____

TO BE COMPLETED BY A LICENSED PHYSICIAN

Name of Medication _____ Purpose of Mediation _____

Dosage of Prescription _____ Time Schedule _____ Dose from (Tablet, Liquid, etc.) _____

Date of Prescription _____ Length of Time To Be Taken _____ Method of Administration _____

DESCRIBE PRECAUTIONS, SPECIAL INSTRUCTIONS, POSSIBLE ADVERSE SIDE EFFECTS, OR OTHER COMMENTS (PLEASE INCLUDE STORAGE INSTRUCTIONS) _____

If the medication is for an ***allergen*,** please state allergen: _____

State foods that need to be OMITTED: _____

The above named student for whom medication is prescribed is under my care.

Print or Type Name of Physician _____ Signature of Physician _____

Address _____ Telephone _____ Date _____

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THIS REQUEST EXPIRES AT THE END OF EACH SCHOOL YEAR