LYNWOOD
UNIFIED SCHOOL DISTRICT

EDUCATIONAL SERVICES

PLEASE USE
ONE FORM
PER MEDICATION

2024-2025 School Year

MEDICATION PERMISSION FORM

(Only needs to be filled out if student currently needs to take medication at school.)

Prescriber's Section

(To be completed by person's with legal prescriptive authority including MD, DO & NP or PA under a practicing physician)

Student's Name:_____ DOB:_____

Diagnosis:_____

Medication Prescribed: _____

Dosage:_____

Route:_____ Time:_____

Possible Side Effects: _____

Duration: To ensure there is no gap in the delivery of medication to students throughout the school year and summer school, **this order is valid one year from the date signed**, unless otherwise specified by the physician here:_____

Prescriber's Name: _____

Address:_____

Phone:_____ Fax:_____

Email:_____

Prescriber's Signature:_____ Date: _____

Prescriber's Stamp:

Parent/Guardian Section

(To be completed by student's legal guardian, or temporary guardian in the case of foster youth)

Parent/Guardian Name: _____

Parent/Guardian Phone Number:_____

Relationship to student: _____

By signing below, I consent to my child receiving prescribed medication at school:

Parent/Guardian Signature:_____ Date: _____