LYNWOOD
UNIFIED SCHOOL DISTRICT
EDUCATIONAL SERVICES

PLEASE USE
**ONE** FORM
PER MEDICATION

# SELF-ADMINISTRATION OF 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 for one year from the date signed**, unless otherwise specified by the physician here: _____

**I request that this student be permitted to carry this medication on his or her person/to be kept in his or her locker/backpack. He or she has been instructed and understands the purpose and appropriate method and frequency of use.**

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:_____ Phone Number: _____

Relationship to student: _____

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

Parent/Guardian Signature:_____ Date: _____