



# LUCERNE VALLEY UNIFIED SCHOOL DISTRICT MEDICATION FORM

School of Attendance: \_\_\_\_\_

Lucerne Valley Unified School District recognizes that it may be necessary for your child to have medication while at school or during school functions. To facilitate this need there are several condition that **must** be met:

- A physician (with a current and valid California Medical Doctor, Doctor of Dental Surgery, Podiatrist, or Nurse Practitioner with furnishing license) must provide written directions and authorization for the medication on this form.
- The parent/guardian authorizes the child to receive medication at school by signing this medication form.
- The medication is brought to the school by the parent/guardian or an adult representative, in a container labeled by a California Pharmacist. Over-the-counter medication must be in the original package.
- A separate form must be completed for each medication and a new form must be completed whenever the prescription changes and at the beginning of each school year.
- You may come to the school to administer medication to your child or you may make arrangements for school personnel to assist in administering medication.
- Students using Auto-Injectable Epinephrine and/or Self-Inhaled Asthma Medication may carry their medication only if this form is complete and on file in the School office.

If this form is not complete and on file your student will not be allowed to have or take any medication (prescribed or over-the-counter) while at school. You may pick up unused medication from the school at any time during the school year. Medication remaining after the last school day will be discarded. Please review the health section of your Parent/Student Handbook or contact the District Health Services Office with your questions

I request that \_\_\_\_\_  
(Name of Student)

be given the following medication during school hours.

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Time to be given

\_\_\_\_\_  
Dosage

\_\_\_\_\_  
Reason for Medication

\_\_\_\_\_  
Possible Side Effects

Parent/Guardian Phone: ( ) - \_\_\_\_\_

Physician's Phone: ( ) - \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**FOR SCHOOL USE ONLY:**

Received – Date: / / By: \_\_\_\_\_

Referred to Nurse – Date: / / By: \_\_\_\_\_