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. All of the above includes over-the-counted medication, which must be brought to the office in the original package. Note: This includes, but is not limited to, cough drops, aspirin, vitamins, Midol, Pepto-Bismol, and antacids.
- 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:________

LVUSD prescription medication form revised 06/2005