Las Lomitas Elementary School District
Inclusive. Engaging. Inspiring.

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LLESD Administration of Medication to a Student Form

Per Education Code 49423 described below, this medication administration form is to be completed and signed by a licensed physician, the student's parent or guardian, and returned to school for inclusion in the student's health record.

> Education code 49423: Notwithstanding the provisions of Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for the pupil by a physician, surgeon, or physician's assistant in compliance with chapter 7.7, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such healthcare provider detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the statement.

The following section is to be completed by the parent/guardian:

School Site: ☐ Las Lomitas ☐ La Entrada	**Student Name (Last, First):** **Student Grade:** TK, K, 1, 2, 3, 4, 5, 6, 7, 8
Teacher: **Grade:** TK, K, 1, 2, 3, 4, 5, 6, 7, 8	**Student DOB**

Please check yes or no for each statement below:

My child may receive assistance taking medication by designated school personnel

- ☐ Yes
- ☐ No

For La Entrada students only:

My child may carry emergency medications (epinephrine, inhalers etc.)

- ☐ Yes
- ☐ No

My child may self administer emergency medications (if child refuses or is unable to self administer, designated school personnel must help)

- ☐ Yes
- ☐ No

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Date: _____/_____/_____

Phone: (_____) _____ - _____

The following section is to be completed by the physician, surgeon, or physician assistant:

	Medication 1	Medication 2
Medication name		
Reason for taking medication		
Dosage/time/instructions		
Form: tablet, liquid, inhaler, injection, other		
Possible reactions		
Discontinue date		

Provider Signature: _____

Provider Printed Name: _____

Date: _____/_____/_____