Queen Creek Unified School District

HEALTH CARE PROVIDER MEDICATION FORM

(To be completed by Health Care Provider)

In order for children to receive medication(s) while at school, the following form (**both parts A and B**) must be completed and returned to the school **prior** to administration of the medication.

A. Health Care Provider's Order for Medication at School

Child's Name_____ **Date of Birth: _____**

Diagnosis medication is prescribed for: _____

Medication to be administered, dosage and mode of administration:

1. Medication Name: _____ Strength:_____
   Dosage at school: _____ Route: _____Time(s)_____
2. Medication Name:_____ Strength:_____
   Dosage at school: _____ Route: _____Time(s)_____
3. Medication Name:_____ Strength:_____
   Dosage at school: _____ Route: _____Time(s)_____

Potential side effects and/or adverse reactions of medication(s): _____

_____

Inclusive dates during which medication is to be given: FROM: _____ **TO:** _____

Controlled medication may not be self-carried. The State of Arizona protects the rights of students to self–carry medications for: 1. Diabetes 2. Asthma 3. Severe Allergic Reactions if the prescribing medication is a rescue inhaler, Epi-pen, or medical equipment and medication for diabetes. **Do you recommend this child, based on provider training and developmental abilities, self-carry this medication? ____YES____NO**

HEALTH CARE PROVIDER'S NAME (Printed) _____ (Signature) _____ Date _____

(To be completed by Parent/Guardian)

B. Parent's/Guardian's Request for Administering Medication at School

I, _____ request that the designated QCUSD staff member give my child, _____ the medication(s) prescribed by our health care provider, _____.

The medication is to be furnished by me and is to be in the original container from the pharmacy with the label matching the written doctor's order. If any changes in medication or dosage occur, the school must be notified immediately and a new form must be completed. Student's misuse of medication being self-administered will result in confiscation and disciplinary action.

I authorize the health care provider to speak with the health office staff regarding my child and their medication(s).

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

HEALTH CARE PROVIDER'S PHONE: _____ **Fax Number:** _____