Queen Creek Unified School District

(**To be completed by Healthcare provider**)

REQUEST FOR SCHOOL ADMINISTRATION OF MEDICATION

In order for children to receive prescription medicine while at school, the following form (**both parts A and B**) must be completely filled out and returned to the school **prior** to its administration.

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

Student'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: _______________________________ Strength: ________________________

Potential Side effects and/or adverse reactions of medication (s): ______________________________________

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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 student, based on provider training and developmental abilities, self-carry this medication? ____YES____NO

HEALTH CARE PROVIDER'S NAME (Printed) ___________________________ (Signature) ______________________ Date _____________

(**To be filled out by Parent**)

B. Parent's Request for Giving Medication at School

I request that the designated QCUSD staff member give my child, ____________________________ the medication 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 physician to speak with the Health Office Staff regarding my child and this medication.

Parent or Guardian Signature: ______________________________________ **Date:** ______________________________

Health Care Provider's Phone: ______________________________________ **Fax Number:** _____________________________