#230-N 08/09

Flagstaff Unified School District #1 Health Services

Request for Medication at School

Name_____ School_____ Grade_____ Teacher_____

Medication_____ Dosage_____ Reason_____

Time to be given_____AM _____PM or ☐ As Needed from (date)_____ to (date)_____

Prescriber's Name/phone:_____ Known Drug or Food Allergy to_____

I hereby request and give my consent for the School Nurse (RN) or person designated by the Administrator to give the above named medication to my child. This request includes authorization for the School Nurse to contact the health care prescriber when necessary. I agree to notify the School Nurse immediately in writing of any change in medication, dose or time of day for the administration.

Parent/Guardian Signature:_____ Date:_____

This consent is good for one school year only.

Prescription medication must be in the original container as prepared by a pharmacist and labeled to include the patient name, name of medication, dosage and time to be given. Please ask for an extra bottle for school use. An over-the-counter medication must be in the original packaging, with all directions, dosages, compound contents and proportions clearly marked. Student misuse of medication being self-administered may result in seizure and disciplinary action. A signed physician's or nurse practitioner's statement indicating the necessity must accompany any request for self-administration of medicine, whether it is prescription or over-the-counter medicine.

Medication count:_____ Date:_____ Signature parent:_____ Signature nurse/designated staff: _____
Medication count:_____ Date:_____ Signature parent:_____ Signature nurse/designated staff: _____
Medication count:_____ Date:_____ Signature parent:_____ Signature nurse/designated staff: _____
Medication count:_____ Date:_____ Signature parent:_____ Signature nurse/designated staff: _____
Medication count:_____ Date:_____ Signature parent:_____ Signature nurse/designated staff: _____
Medication count:_____ Date:_____ Signature parent:_____ Signature nurse/designated staff: _____

Unlicensed Assistive Personnel Documentation

Date	Time	Name of Medication	Route	Signature	Comments