P E O R I A

Unified School District No. 11

MEDICATION PROCEDURE

CONSENT TO ADMINISTER PRESCRIPTION MEDICATION AND OVER-THE-COUNTER MEDICATION

It is strongly recommended that medication be administered at home if at all possible. ALL MEDICATION must be kept in the Health Office. If students must take medication at school, either by physician's order or parent's request, the following guidelines will apply:

Administration of Medication Prescribed By a Physician

- The law (ARS15-344) requires that medication must be delivered to the nurse in the prescription container as prepared by the pharmacist. The number of pills may be documented upon receipt by the school nurse.
- The prescription label must bear the student's name, current date, name of medication, dosage and the time to be given.
- Please ask your pharmacist to fill the prescription in both home and school containers.
- It is recommended that more than a 30 day supply be maintained at school.
- The school nurse may consult with the physician regarding medication.

Administration of Non-Prescription Medications

- The law (ARS 15-344) requires that medication must be delivered to the nurse in the original container as packaged by the manufacturer and labeled with the student's name.
- Dosage must be in keeping with the manufacturer's recommendations as printed on the label.
- The school nurse may request a medical evaluation and may require a physician's order giving permission to administer non-prescription medication, non-traditional medication or food supplements.
- A printed form provided by the district must be completed by the parent/guardian authorizing administration of medication and/or food supplements at school. A temporary hand-written may be honored for one dose/day and must be followed by school district form.
- Medication should not be carried back and forth from home to school by the student. This is protect the student against theft or misuse of his/medication.

Please complete the following information and return the entire page to the school nurse

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Name_____ Date of Birth _____ Grade _____

Teacher _____ Medication _____ Dosage _____

Reason for Medication (diagnosis) _____ Time(s) to be administered at school _____

Dates to be administered at school: From _____ (Date) Until _____ (Date)

I hereby authorize the school nurse or Principal's designee to be agent and to give the above named medication(s) to my child.

Signature of Parent/Guardian _____ Date _____