LITCHFIELD ELEMENTARY SCHOOL DISTRICT
272 East Sagebrush Street • Litchfield Park, Arizona 85340 • 623.535.6000 • Fax 623.935.1448 • www.lesd.k12.az.us
"A Stronger Mind for a Stronger Future"

MEDICATION GUIDELINES

[ ]Barbara B. Robey	[ ]Litchfield	[ ]Scott L. Libby	[ ]Western Sky
[ ]Belen Soto	[ ]Corte Sierra	[ ]Mabel Padgett	[ ]Verrado ES
[ ]White Tank LC	[ ]Dreaming Summit	[ ]Palm Valley	[ ]Verrado Heritage
[ ]Wigwam Creek	[ ]L. Thomas Heck	[ ]Rancho Santa Fe	[ ]Verrado MS

Child: _____ Homeroom Teacher (If applicable):_____

Dear Parent/Guardian:

It is the belief of the Governing Board that medication should be administered at home. However, under certain conditions, it is in the best educational and health interests of the child to take prescribed medications during the school day. Bring your child's medication to the health center. Do not send medication to school with your child.

We are asking for your cooperation regarding giving medication in the schools. Because of the responsibility placed upon the staff for giving the correct medications, we ask that you comply with the following guidelines:

1) Prescription medication must be in the original container as prepared by a pharmacist and labeled, including the patient name, name of medication, dosage, and time to be given. (See Request for Giving Medication at School form)
2) Any changes to prescription medications must be reflected on a new prescription bottle and with most current labeling. (See Request for Giving Medication at School form)
3) Parent or Guardian must sign the Request for Giving Medication at School form.
4) The student is responsible for coming to the Health Center or to the designated person to take medications.
5) Nonprescription medications must be in original packaging and can be administered to students who have written permission from a parent or guardian in accordance with the directions on original packaging. Physician's orders must be obtained if parent/guardian requests to administer the medication beyond the labeled directions.
6) Students may not carry or administer their own medication except with written permission. (See Special Request to Carry and Self-Administer Medication form). This includes inhalers, prescriptions, and over the counter medications.
7) Parents are responsible for providing medications for overnight field trips.
8) Pick up your child's medication no later than the last day of the school year. Any medications that are not picked up at the end of the school year will be discarded.
9) A new Medication Guidelines form must be signed every school year.

If you have any questions regarding the Medication Guidelines, please contact the Nurse at your child's school.

I HAVE READ THE LITCHFIELD ELEMENTARY SCHOOL DISTRICT MEDICATION GUIDELINES.

Signature of Parent/Guardian: _____ Date:_____

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Written permission is necessary before any medication can be given to your child. If written permission isn't available then verbal permission may be obtained for each episode. Written permission is valid for each school year. If you have any questions regarding this, please contact the Health Center.

---Please complete form and return to school health center---
2020/2021

Child's Name:_____ Grade:_____

Homeroom Teacher (if applicable):_____

In case of minor accident or illness, I give permission for my child, to receive any of the following medications. Areas checked **YES** may be dispensed to my child.

YES	NO	
☐	☐	Acetaminophen (Tylenol for headache, menstrual cramps, etc.)
☐	☐	Ibuprofen (Motrin for headache, menstrual cramps, etc.)
☐	☐	Antacid (upset stomach)
☐	☐	Throat Lozenges (sore throat)
☐	☐	Salt Water Gargle (sore throat)
☐	☐	Caladryl (insect bite/itching)
☐	☐	Lip Balm/Vaseline (chapped lips)
☐	☐	Benadryl (Antihistamine for allergic reactions, etc.)

It is noted that alternate methods of care will be used before medication is given.

Please note any known allergies or chronic health conditions.

Physician's Name _____ Phone _____

Allergies: Food _____

Medication _____

Other_____

Chronic Health condition(s): _____

Currently taking medications (please list):_____

Parent/Guardian Signature_____ Date_____

Please contact your school nurse to discuss any questions or concerns.