Teacher: ________________ Grade: ________
Medication Expiration Date: ________________
Medication Allergies: ____________________
Count: ______ Date: _____ Initials: ____/____
Count: ______ Date: _____ Initials: ____/____
Count: ______ Date: _____ Initials: ____/____

Cave Creek Unified School District #93

School Health Office:	☐ BMES	☐ DSA	☐ DWES	☐ HTES
Phone:	480-575-2102	480-575-2902	480-575-2802	480-272-8502
Fax:	480-488-6708	480-502-2364	480-419-7265	480-907-6643
	☐ LMES	☐ STMS	☐ CSHS	
Phone:	480-437-3002	480-272-8602	480-575-2402	
Fax:	480-595-1312	480-272-8699	480-488-6701	

PARENT'S/GUARDIAN'S CONSENT FOR GIVING MEDICATION AT SCHOOL

I hereby request and give consent for the school nurse or person designated by the administrator to give the following medication as directed. I understand the Health Office does not supply any medication to students. All medication is to be brought to and from the Health Office by parents/guardians.

The Health Office does not administer expired medication. All medication must be age appropriate.

Student name: ______________________________ Grade: _______ Name of medication: __________________________

☐ Prescription ☐ Over-the-counter ☐ Daily ☐ PRN (as needed) Prescription #: __________ Expiration date: ___________

Amount/dosage to be given: _________ Time to be taken: _______ Route: _______ Reason for medication: _________________

Duration of treatment: _______________ Prescriber's name (must be on label): _____________________________________

Student allergies: _______________________________ Other medication(s) being taken: ____________________________

I furnish this medication and if it is a prescription, it must be in the original pharmacy bottle, labeled with my child's name, prescription number, name of medication, dosage, route, and the number of times a day medication is to be administered. **The Health Office has a small volume nebulizer but the parent/guardian must provide individual tubing and mask or T-piece.**

If it is an over the counter medication, it must be in the original container, the date, the time to be given, route, the amount to be given must be entered above. All medication must be brought to the Health Office where it will be kept in a locked cabinet. The student must take his/her medication in the Health Office. The school district personnel will not be responsible or liable for any reaction to the medication(s) given.

THE SCHOOL MUST BE NOTIFIED IMMEDIATELY IN WRITING OF ANY CHANGE IN MEDICATION.

Signature Parent/Guardian: ____ Date: ______________________

Home phone number: (____) ___________ Cell phone number: (____) ____________ Work number: (_____) __________

This portion completed by the Health Office staff when medication picked up or discarded

Date medication picked up: ______________ Signature Parent/Guardian: ________________________________

RN or HA signature: ___________________________________ RN or HA signature: ___________________________

Discard/expired ☐ Expiration date: ____________________ ☐ Discarded/left after pick up date: ___________________

 ☐ Self-addressed envelope ☐ End of year letter Date sent: _______________________