KyreneSchoolDistrict

Consent for Giving Prescription and Non-Prescription Medications at School

© 5-404

Please check here if **NON**-prescription ☐

Student Name:_____DOB:_____

School:_____Grade:_____Date: _____

A Physician, Nurse Practitioner or Physician Assistant **must** complete and sign the information below for prescription and non-prescription medication, except for emergency administration pursuant to A.R.S. §15-157 (Epinephrine auto-injector) or A.R.S. § 15-158 (Inhalers) or A.R.S. § 15-341, subsection A, paragraph 43, (naloxone hydrochloride/any other opioid antagonist). Parent/Guardian signature is required for both prescription and non-prescription medication. Medication must be delivered to school in the original container with the label intact. The medication is to be given in the following manner:

Name of Medication: _____ Strength of Medication: _____

Amount to be Given: _____Time of Administration at School: _____

Route of Administration (by mouth, etc): _____ Reason for Medication: _____

Comments and/or Instructions: _____

Date Medication is to be discontinued: _____

Any Known Allergies: _____

Licensed Healthcare Provider Name: _____Phone No._____
(print)

_____
Licensed Healthcare Provider Signature Date

I authorize the School District and its employees and agents, on my behalf, to assist in the administration of the medication identified as ordered by my child's Physician, Nurse Practitioner or Physician Assistant. **I acknowledge that an administrator may designate school staff to administer the medication.**

I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation, and maintenance of above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. I give permission for the exchange of information directly with the healthcare provider regarding my child's medication. Parents/Guardians should pick up unused medications at the close of the school year. Medications remaining after the last day of the school year will be discarded.

_____
Parent/Guardian Name (Printed) Parent/Guardian Signature Date

_____
Parent/Guardian Home Phone # Parent/Guardian Work Phone #

OFFICE USE ONLY			
MEDICATION COUNT AND INITIALS			
Count	Date	Health Assistant Initial	Parent/Guardian Initial

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