

**Gilbert Public Schools  
Health Services Department**

**REQUEST FOR SCHOOL ADMINISTRATION OF PRESCRIPTION MEDICATION**

In order for children to receive medicine while at school, the following form (both parts A and B) must be completely filled out and returned to the school prior to its administration.

School Year \_\_\_\_\_ - \_\_\_\_\_

**A. Parent's Request for giving Medication at School (To be filled out by parent/legal guardian)**

I request that the designated staff member give my child, \_\_\_\_\_  
Student's Name

the medication prescribed by our health care provider \_\_\_\_\_  
Name of Provider

The medication is to be furnished by me and is to be in the original container from the pharmacy with the label matching the written doctor's order. If any changes in medication or dosage occur, the school must be notified immediately and a new form must be completed. Student's misuse of medication being self-administered will result in confiscation and disciplinary action. I authorize the physician to speak with the Registered Nurse regarding my child and this medication.

I DO  I DO NOT  consent to transmission of my child's medical records electronically.

\_\_\_\_\_  
Signature of Parent / Guardian Date

\_\_\_\_\_  
Work Phone Home Phone E-Mail address or Fax #

**B. Health Care Provider's Order for Medication at School (To be filled out by Provider)**

I request the following student be given medication at school because I believe there exists a valid health reason which makes the administration of medication advisable during the time a student is under supervision of school officials.

\_\_\_\_\_  
Student's Name Birthdate

\_\_\_\_\_  
Condition being treated Medication to be administered

\_\_\_\_\_  
Dosage and mode of administration Time to be given at school

\_\_\_\_\_  
Inclusive dates during which medication is to be given

\_\_\_\_\_  
Side effects to be expected. What emergency measures should be taken if this occurs?

\_\_\_\_\_  
Other medications being taken at home or at school

\_\_\_\_\_  
Health Care Provider's Name (Print) Health Care Provider's Signature

\_\_\_\_\_  
Address Date

\_\_\_\_\_  
Health Care Provider's Phone # Health Care Provider's Fax #

For Office Staff Only

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Rx #: \_\_\_\_\_ Exp Date: \_\_\_\_\_

## Medication Requirements

Please read the medication requirements below carefully and contact us with any questions.

Per District Policy JLCD

Prescription medication must be sent in the original container with label showing:

- student's name
- name and strength of the medication
- specific instructions for administration (time, dose etc)

The pharmacist can provide the parent with an extra container with the prescription label for the school.

- We cannot split pills! If the dose requires the pill to be split, please split the medication before bringing it to school.
- An adult **MUST** deliver medication to the school.
- We cannot accept more than 30 days of medication at a time.
- The medication will need to be counted with the nurse/health assistant at drop off.