Deer Valley Unified School District No. 97

# Parent Request for Student to Carry and Self-Administer Emergency Medications for Treatment of Asthma, Anaphylaxis or Seizures

I request that my student _____ Grade ____ , be allowed to keep on their person, take when necessary, and assume responsibility for the medication listed below, beginning (date) _____ to ____5/22/2025___ at (time) _____ or as needed (PRN) per labeled instructions.

**FOR PRESCRIPTION MEDICATIONS ONLY**

Name of Medication: _____ Dose: _____

Mode of Administration: _____ Condition Being Treated: _____

Directions: _____

Name of Medication: _____ Dose: _____

Mode of Administration: _____ Condition Being Treated: _____

Directions: _____

This medication is to be furnished by the parent and must come in the original container with a pharmacy label that includes the student's name, prescription number, name of medication and the dosage to be administered. An exception would be Benadryl for treatment of anaphylaxis.

The STUDENT is responsible for this medication. The student is to keep this medication in their possession at all times and must NEVER share it with other students. Failure to comply with these rules may result in disciplinary action per DVUSD policy. Deer Valley School District #97 personnel will not be held responsible for any adverse reaction to the above mentioned medication. This form must be approved by the nurse in order to be valid. Once approved, this form is valid for one school year and must accompany the medication at all times.

_____ _____

Parent/Guardian Signature Date Signed

Approved by: _____ Date: _____

(School Nurse)

Approved for the ____2024-2025____School Year

Rev 5/22 jd