

SCHOOL:

Entries are Computerized

[illegible]

DEER VALLEY UNIFIED SCHOOL DISTRICT # 97
PARENT'S REQUEST FOR GIVING MEDICATION AT SCHOOL

I request that the school nurse or my agents (Principal/Designee) see that

Student's Name _____ receives this medication from _____ to _____ Date _____

Date _____ at _____ Time _____ for _____ Reason for Medication _____

Medication _____ Dosage _____

This medication is furnished by me, and if it is prescription *, it is in its original pharmacy bottle, labeled with my child's name, prescription number, and identification of medication. If it is an over-the-counter medication, it is to be in its original container. The date, time given, and amount given should be entered above. School district personnel will not be responsible or liable for any reaction to medicines given according to the above direction. All medication will be kept in a locked cabinet in the nurse's office and dispensed from there. I understand it is my responsibility to monitor medication supply and provide additional medication when needed.

*If the medication is a sample given by the physician, please provide a signed note from the physician telling who the medication is for, the date, and instructions for giving the medication.

I understand that my child may receive medication administered by a nursing student, under the direct supervision of the school's nurse, and give my consent for this.
Please initial one: Yes _____ No _____

Other medications currently taken by my child: _____

PARENT'S SIGNATURE _____ DATE SIGNED _____

TEACHER _____ GRADE _____

Contact Email: _____

3/2023

For Office Use: Doctor Order Received _____ Date _____

Medication Brought to School

DATE _____ AMT _____ SIGNATURES _____ / _____
DATE _____ AMT _____ SIGNATURES _____ / _____
DATE _____ AMT _____ SIGNATURES _____ / _____
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DATE _____ AMT _____ SIGNATURES _____ / _____
DATE _____ AMT _____ SIGNATURES _____ / _____

EARLY RELEASE DAYS

I request my student **RECEIVE / DOES NOT RECEIVE** medication at School on early release days. (circle appropriate answer)
Parent Signature _____

END OF YEAR MEDICATION DISPOSITION
AT THE END OF THE NEED OR THE END OF THE SCHOOL YEAR:**

Please initial one of these statements:
_____ I WILL PICK UP MY STUDENT'S REMAINING MEDICATION.
_____ PLEASE DESTROY ANY REMAINING MEDICATIONS.

****DISCONTINUED MEDICATIONS WILL BE RETAINED FOR THREE DAYS, THEN DESTROYED. MEDICATIONS NOT PICKED UP WITHIN ONE DAY OF THE END OF SCHOOL YEAR WILL BE DESTROYED.**

Date picked up _____ Signature _____
Date meds destroyed _____
Amount picked up _____