DEER VALLEY
Unified School District

Date: **2026-2027** School Year

Dear Parents/Guardian,

In accordance with the Arizona School Board Association and the DVUSD Governing Board Policy JLCD, concerning administration of medication at school, there is a requirement in order to give prescribed medications and dietary supplements in the school setting.

A written doctor's order will be required per Governing Board Policy JLCD "Medicines/Administering Medicines to Students".

"There shall be a written order from the physician stating the name of the medicine, the dosage, and the time it is to be given." The prescribing physician must renew this order each school year.

We have prepared a form for you to take to your physician to complete and return to the School Nurse. No prescription medication or dietary supplement will be given without the written orders from your prescribing physician or other qualified health care professional. This form can be obtained from your school nurse.

This requirement is in addition to the Parents Request for Giving Medication at School Form and will be enforced at the beginning of each school year. All other requirements remain in accordance with DVUSD School policy.

If you have any questions you may contact your school nurse.

Sincerely,

Health Center Nurse: Jan Rey RN, BA-FLE

Office: 623-3.76-5010. Fax: 623-376-5080

Email: Jan.Rey@dvusd.org

DEER VALLEY Unified School District

Medical Authorization to Administer Medication or Dietary Supplement to Student and Authorization for Release of Health Information

Health Care Provider Order for School to Administer Medication (prescribed) or Dietary Supplement.

I request the following student be given medication at school because I believe there exists a valid health reason which necessitates medication administration during the school day.

This Order Good for School Year: 2026-2027

_____ _____

Student Name **Birthdate**

_____ _____

Medication #1 **Time to be administered at school**

_____ _____

Condition being treated (Include ICD 10 Code) **Dosage and mode of administration.**

_____

Side Effect to be expected, if any. (What emergency measures should be taken if this occurs?)

_____ _____

Medication #2 **Time to be administered at school**

_____ _____

Condition being treated (Include ICD 10 Code) **Dosage and mode of administration.**

_____

Side Effect to be expected, if any. (What emergency measures should be taken if this occurs?)

_____

Other medications the School should be aware of.

_____ _____

Health Care Provider Name (Printed) **Health Care Provider Signature**

_____ _____

Address **Date**

_____ _____ _____

Telephone **Fax** **Email**

Parent agrees that the school nurse may contact physician with questions regarding the above medication and possible side effects as needed and the exchange of medically necessary information between both Health Care professionals.

_____ _____

Parent Signature and Printed Name **Date**

School Nurse JAN REY RN Phone No. 623-376-5010 Fax No. 623-376-5080

02/25/22 jd