PEORIA UNIFIED SCHOOL DISTRICT

MEDICATION PROCEDURE FORM

CONSENT TO ADMINISTER PRESCRIPTION MEDICATION AND OVER-THE-COUNTER MEDICATION

It is strongly recommended that medication be administered at home if at all possible. **ALL MEDICATION** must be kept in the Health Office. If students must take medicine at school, either by physician's order or parent's request, the following guidelines will apply:

Administration of Medication Prescribed by a Physician

- The law (ARS15-344) requires that medication must be delivered to the nurse in the prescription container as prepared by the pharmacist. The number of pills may be documented upon receipt by the school nurse.
- The prescription label must bear the student's name, current date, name of medication, dosage and the time to be given.
- Please ask your pharmacist to fill the prescription in both home and school containers.
- It is recommended that no more than a 30 day supply be maintained at school.
- The school nurse may consult with the physician regarding medication.

Administration of Non-Prescription Medications

- The law (ARS 15-344) requires that medication must be delivered to the nurse in the original container as packaged by the manufacturer and labeled with the student's name.
- Dosage must be in keeping with the manufacturer's recommendations as printed on the label.
- The school nurse may request a medical evaluation and may require a physician's order giving permission to administer non-prescription medication.
- A printed form provided by the district must be completed by the parent/guardian authorizing administration of medication and/or food supplements at school. A temporary hand-written note may be honored for one dose/day and must be followed by the school district form.
- Medication should not be carried back and forth from home to school by the student. This is to protect the student against theft or misuse of his/her medication.

Please complete the following information and return the entire page to the school nurse.

STUDENT'S NAME		BIRTHDATE	TEACHER	GRADE
MEDICATION WITH PRESCRIPTION NUMBER	DOSAGE/FREQUENCY		REASON FOR MEDICATION (DIAGNOSIS)/SYMPTOMS	
TIME(S) TO BE ADMINISTERED AT SCHOOL	DATES TO BE ADMINISTERED AT SCHOOL FROM (DATE)		UNTIL (DATE)	

I hereby authorize the school nurse or Principal's designee to be my agent and to give the above named medication(s) to my child.

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Signature of Parent/Guardian **Date**