CATALINA FOOTHILLS SCHOOL DISTRICT
HEALTH SERVICES

REQUEST FOR GIVING MEDICATION AT SCHOOL

STUDENT:_____ **GRADE/ TEACHER:** _____

Name of Medication:_____

Dosage: _____

Expiration date: _____

Time to be given:_____

Expected duration of treatment: From_____To_____

Prescriber's Name: _____

Reason for medication:_____

Known Drug or Food Allergy:_____

Parent/Guardian Signature: _____**DATE:**_____

When it is essential to a student's health that medicine (including OTC) be taken during school hours:

- There must be a written order from a licensed Arizona PCP stating the name of the medicine, the dosage and the time it is to be given. Parent consent form must be completed. Medication must be FDA approved.
- The medication must be in the original pharmacy or OTC container.
- Forms for student's to carry and self-administer Epi-pens and Inhalers are available from the health office.
- Parents of Pre K-8th graders must hand deliver prescription medication to the school health office.
- Supervision of medication administration protocol is managed by a Registered Nurse. In the nurse's absence, medication will be administered by an agent/district employee designated by the principal; usually the health assistant or office secretary.

Physician Signature _____Print Physician Name_____

Physician Phone _____Physician Fax _____

***Physician Signature authorizes administration of the above OTC medicine, in the dosage indicated above, by School Nurse or designee.**

Date medication returned to parent	Amount returned	Parent Signature	RN/ HA initials