MEDICATION REQUEST:

STUDENT _____ Grade _____

Note: **Prescription Medication must be in the original container indicating the following information: student name, dosage, healthcare provider, pharmacy, date issued, and prescription number. Over the counter medication must be in original, unopened package with students name on the outside. All medication must be brought in by an adult. Do not send in any medication (including cough drops) with student.**

PARENT STATEMENT:

- I request that the following medication be given to my child named above.
- For this condition_____
- I understand that only current medications will be given at school.
- I understand that in the absence of the school nurse, other school personnel will administer the medication.
- I will notify the school immediately if the medication is changed and understand that the nurse may contact the health care provider or pharmacist regarding this medication.
- ***I understand that this medication will be destroyed unless picked up by the end of the last student school day of the year.***

Medication _____ Dose _____
Time/dosage to be given _____
Begin Date _____ End Date _____
Possible Side Effects _____
Healthcare Provider _____ Phone _____

As parent/guardian of the above named student, I request Happy Valley East to give medication to my child.

_____
Parent/Guardian Printed Name

X_____ Date _____ Phone _____
Parent/Guardian Signature

X_____ Date _____ Phone (480) 888-1342 x 208
School Nurse Signature