

Lake Havasu Unified School District No. 1

MEDICATION ADMINISTRATION TO STUDENTS

Request for giving Medicine at School

Name _____ Grade _____ Birth Date _____

Medication _____ Route _____

Dosage _____ Time _____ A.M. Time _____ PM

Diagnosis/reason for giving _____

Dates from _____ to _____

Comments _____

Prescription medication must be in the original container as prepared by a pharmacist and labeled, including the patient name, name of medication, dosage and time to be given. An over-the-counter medication must be in the original packaging, with all directions, dosages, compound contents, and proportions clearly marked. All medication must be FDA approved.

Medication must be brought to the health office by a parent or guardian.

As parent/guardian of the named student, I hereby authorize the mutual exchange of confidential information between Lake Havasu Unified School District and:

Agency/practitioner: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Parent's or Guardian's Signature

Date

A signed physician's statement indicating the necessity must accompany any request for self-administration of medicine, whether it is prescription or over-the-counter medicine except in the case of medication for diagnosed anaphylaxis and breathing disorders requiring handheld inhaler devices. In these cases the student's name on the prescription label is sufficient for the physician's recommendation. Student misuse of medication being self-administered may result in seizure and disciplinary action.

Nursing Notes

