Gilbert Public Schools
Health Services Department

REQUEST FOR SCHOOL ADMINISTRATION OF PRESCRIPTION MEDICATION

In order for children to receive medicine while at school, the following form (both parts A and B) must be completely filled out and returned to the school prior to its administration.

School Year _____ - _____

A. Parent's Request for giving Medication at School (To be filled out by parent/legal guardian)

I request that the designated staff member give my child, _____
Student's Name

the medication prescribed by our health care provider _____
Name of Provider

The medication is to be furnished by me and is to be in the original container from the pharmacy with the label matching the written doctor's order. If any changes in medication or dosage occur, the school must be notified immediately and a new form must be completed. Student's misuse of medication being self-administered will result in confiscation and disciplinary action. I authorize the physician to speak with the Registered Nurse regarding my child and this medication.

I DO ☐ I DO NOT ☐ consent to transmission of my child's medical records electronically.

_____ _____
Signature of Parent / Guardian Date

_____ _____ _____
Work Phone Home Phone E-Mail address or Fax #

B. Health Care Provider's Order for Medication at School (To be filled out by Provider)

I request the following student be given medication at school because I believe there exists a valid health reason which makes the administration of medication advisable during the time a student is under supervision of school officials.

_____ _____
Student's Name Birthdate

_____ _____
Condition being treated Medication to be administered

_____ _____
Dosage and mode of administration Time to be given at school

_____
Inclusive dates during which medication is to be given

_____
Side effects to be expected. What emergency measures should be taken if this occurs?

_____
Other medications being taken at home or at school

_____ _____
Health Care Provider's Name (Print) Health Care Provider's Signature

_____ _____
Address Date

_____ _____
Health Care Provider's Phone # Health Care Provider's Fax #