

MESA PUBLIC SCHOOLS
CONSENT FOR SCHOOL TO ADMINISTER MEDICATION
OR DIETARY SUPPLEMENT TO STUDENT AND
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PART A

Parent Request for School to Administer Medication
(OTC or Prescribed) or Dietary Supplement

Part A must be completed for School to administer any medication (OTC or prescribed) or dietary supplement to a student.

I request the School to give my child, _____ this medication: _____
STUDENT NAME NAME OF MEDICATION

Time to be given: every _____ hours as needed or at _____ daily. Dates from _____ to _____.

I acknowledge: (1) The School will not administer any medication for more than five consecutive school days unless the request is accompanied by PART B – Health Care Provider Order. (2) I must supply all medication in the original container and, if prescription medication, the container must have a label identifying the pharmacy, dose instructions, and issuing health care provider. (3) If a medication or dosage is changed, I will notify the School immediately and complete a new Consent form. (4) The School will confiscate and take disciplinary action if the Student misuses medication, including unauthorized possession or self-administration. (5) If I have provided a completed PART B, I authorize the School to speak with my health care provider regarding my child's medication or dietary supplement. Medication not picked up by the end of the school year will be destroyed.

PARENT OR GUARDIAN NAME (PRINTED) PARENT OR GUARDIAN SIGNATURE

DATE HOME PHONE WORK PHONE EMAIL

PART B

Health Care Provider Order for School to Administer Medication
(OTC or Prescribed) or Dietary Supplement

Part B must be completed for School to administer medication (OTC or prescribed) or dietary supplement to a student for more than five consecutive school days.

I request the following student be given medication at school because I believe there exists a valid health reason which necessitates medication administration during the school day.

STUDENT NAME BIRTHDATE

MEDICATION TIME TO BE ADMINISTERED AT SCHOOL

CONDITION BEING TREATED DOSAGE AND MODE OF ADMINISTRATION

SIDE EFFECTS TO BE EXPECTED, IF ANY. (WHAT EMERGENCY MEASURES SHOULD BE TAKEN IF THIS OCCURS?)

OTHER MEDICATIONS THE SCHOOL SHOULD BE AWARE OF

HEALTH CARE PROVIDER NAME (PRINTED) HEALTH CARE PROVIDER SIGNATURE

HEALTH CARE PROVIDER ADDRESS

DATE TELEPHONE FAX EMAIL