Phoenix Union High School District
Student Health Services and Exceptional Student Services

REQUEST TO ADMINISTER MEDICATION PARENT PERMISSION FORM
SOLICITUD DE ADMINISTRACIÓN DE MEDICAMENTOS FORMULARIO DE PERMISO PARA PADRES

Student Name: ____ School Year: ___________________

Student ID Number: _________________________________ Date of Birth: _________________________ Grade: ________

Physician Name: ____ Telephone: ____________________________

Under certain circumstances, when it is necessary for a student to take medicine during school hours, Phoenix Union High School District will cooperate with the treating physician or healthcare provider and the parent or guardian if the following requirements are met:

- Medications will NOT be administered and/or medical procedures will NOT be performed at school without prior written permission from the parent/guardian and written orders from the physician/healthcare provider licensed in the State of Arizona.
- The medications must be brought to school by the parent or guardian in the original container dispensed by the pharmacy with a current medication label to include the prescribing physician or healthcare provider name, student name, medication name, dosage, route, time to be administered, any special instructions.
- Over-the-counter school approved medications must be brought to school by the parent or guardian in the original sealed container with all warnings and directions intact with written permission required by the parent/guardian.
- Bus transportation personnel cannot transfer medications to or from school.
- Cannabis oils, narcotics and medical marijuana products prescribed for pain or other medical conditions are NOT allowed on school grounds.
- The parent/guardian should retrieve the student's medications and all equipment/supplies at the end of each school year; medications and/or equipment/supplies will be disposed of properly if not retrieved by the last day of school.

I authorize to allow authorized trained school personnel to administer prescribed medications and perform medical procedures as ordered by the physician/healthcare provider licensed in Arizona. I authorize the school to notify the Emergency Contact Names listed, in the event that I cannot be available by telephone and allow the Emergency Contact to pick-up my child from school. I understand that for emergent situations, school personnel will call 9-1-1 when needed. I authorize school personnel to contact my child's physician or dispensing pharmacist to obtain, exchange, or release any medical information needed for my child's care. The parent/guardian is also responsible for notifying the school anytime there is a change in orders, medications, and/or in the student's medical condition.

Parent/Guardian Signature: ____ **Date:** _________________

Telephone Cell: _________________________ **Work:** ______________________ **Home:** _______________________

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Medication Name: ____ Reason: ________________________________

Dosage: ____________________________________ Route: __________ ☐ Only As Needed ☐ Rescue Med

Time Given at School: _______________ am/pm _________________ am/pm ______________ am/pm

Special Instructions: ____

Any known medication, food, environmental allergies: ☐ No ☐ Yes, please list and type of reaction:
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☐ Prescribed medication must have a current pharmacy label to include student name with healthcare provider written orders attached to the original container dispensed by the pharmacy with written permission given by the parent/guardian.

EACH MEDICATION WILL REQUIRE A SEPARATE FORM TO BE COMPLETED AND SIGNED BY THE PARENT/GUARDIAN

Board Policy Adopted 2/2/17 – JLCD Medicines/Administering Medications to Students
Resource Arizona School Board Association (ASBA) Policy Bridge; Form revised 3/10/19, 7/24/19

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MEDICATION RECEIVED INVENTORY

Drug Form (Tablet, Liquid, Inhaler, etc.)	Amount	Original Container with Pharmacy Label MD Written Order	Expiration Date	Date Received and Staff Initials
		Y N		
		Y N		

MEDICATION RETURN OR DISPOSAL

Reason for Return or Disposal of Medication	Amount	Date Parent/Guardian Notified of Expiration, Replacement Need, or Return of Medication (End of the School Year)	Date of Return or Disposal and Two Initials (Parent and Staff)

FIELD TRIP/SCHOOL RELATED ACTIVITY – MEDICATION RELEASE FROM HEALTH OFFICE

Date of Field Trip	Amount Taken	Original Container with Pharmacy Label MD Written Order	Name of Staff Requesting Medication and Initials	Date Medication Returned, Name of Staff and Initials
		Y N		
		Y N		

Additional Comments:

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Nombre del Alumno: ____ Año Escolar : ________________

Número de Identificación del Alumno:_______________________Fecha de Nacimiento : ________________Grado: _______

Nombre del Medico: ____ Telephono: _________________________

Bajo ciertas circunstancias, cuando sea necesario que un estudiante tome un medicamento durante las horas escolares, el Distrito Escolar de Phoenix Union High cooperará con el médico tratante o proveedor de atención médica y el padre o tutor si se cumplen los siguientes requisitos:

- Los medicamentos NO se administrarán y / o los procedimientos médicos NO se realizarán en la escuela sin el permiso previo por escrito del padre / tutor y las órdenes escritas del médico / proveedor de atención médica con licencia en el estado de Arizona.
- Los medicamentos deben ser traídos a la escuela por el padre o tutor en el envase original dispensado por la farmacia con una etiqueta de medicamento actual que incluya el nombre del médico que prescribe o del proveedor de atención médica, el nombre del estudiante, el nombre del medicamento, la dosis, la ruta, el tiempo para ser administrado , instrucciones especiales.
- Los padres o tutores legales deben traer a la escuela los medicamentos aprobados sin receta en el contenedor original sellado con todas las advertencias e instrucciones intactas con el permiso por escrito del padre o tutor.
- El personal de transporte en autobús no puede transferir medicamentos hacia o desde la escuela.
- Los aceites de cannabis, los narcóticos y los productos de marihuana medicinal prescritos para el dolor u otras afecciones médicas NO están permitidos en los terrenos de la escuela.
- El padre / tutor debe recuperar los medicamentos del estudiante y todos los equipos / suministros al final de cada año escolar; los medicamentos y / o equipos / suministros se desecharán adecuadamente si no se recuperan el último día de clases.

Autorizo a permitir que personal escolar capacitado autorizado administre los medicamentos recetados y realice procedimientos médicos según lo indique el médico/proveedor de atención médica con licencia en Arizona. Autorizo a la escuela a notificar a los nombres de contacto de emergencia que figuran en la lista, en caso de que no pueda estar disponible por teléfono y permitir que el contacto de emergencia recoja a mi hijo de la escuela. Entiendo que para situaciones de emergencia, el personal de la escuela llamará al 9-1-1 cuando sea necesario. Autorizo al personal de la escuela a contactar al médico de mi hijo o al farmacéutico dispensador para obtener, intercambiar o divulgar cualquier información médica necesaria para el cuidado de mi hijo. El padre/tutor también es responsable de notificar a la escuela en cualquier momento que haya un cambio en las órdenes, medicamentos y / o en la condición médica del estudiante.

Firma de Padre o Tutor: ____ **Fecha:** _______________

Teléfono Móvil: ________________________ **Trabajo:** ______________________ **Casa:** _______________________

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Medication Name: ____ Reason: ________________________________

Dosage: ____________________________________ Route: __________ ☐ Only As Needed ☐ Rescue Med

Time Given at School: _______________ am/pm _______________ am/pm ______________ am/pm

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