SCHOOL YEAR 2019-2020

PRESCRIPTION MEDICATION REQUEST: LONG TERM

STUDENT _____ **SCHOOL** _____

Note: Prescription Medication must be in the original container indicating the following information: student name, dosage, healthcare provider, pharmacy, date issued, and prescription number.

Parent Statement :I request that the prescription medication listed below be given to my child.

- I authorize and delegate that in the absence of the school nurse, other school personnel may 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 this year per federal DEA requirements.*

*Parent/Guardian Signature*_____ *Date*_____

Home phone _____ *Work/Emergency Phone*_____

Other medications your child is taking _____

Health Care Provider Statement :This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication. The above named child should receive prescribed medication for the following condition: _____

_____

- **Medication**_____
- **Prescribed daily dosage** _____
- **Time and dosage given at school**_____
- **Beginning date of medication**_____ **Ending Date**_____
- **Possible side effects**_____

Healthcare Provider Signature _____ ***Date*** _____
Printed Name _____***Phone***_____
Healthcare Provider Address_____

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