



# HAPPY VALLEY SCHOOL

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★ CHARACTER ★ LEADERSHIP ★ ACADEMIC SUCCESS

## PRESCRIPTION AND OVER THE COUNTER MEDICATION REQUEST: LONG TERM School Year – 2020-2021

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. All medication (including prescription or over the counter) must be brought to the office by a parent, students are not allowed to deliver it to campus.

**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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