



**PRESCRIPTION AND OVER THE COUNTER MEDICATION REQUEST: LONG TERM
School Year 2023-2024**

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 _____