HAPPY VALLEY SCHOOL
7140 W. Happy Valley Road Peoria, AZ 85383
(623) 376-2900 (623) 376-9030 fax www.happyvalleyschool.org
CHARACTER LEADERSHIP ACADEMIC SUCCESS

PRESCRIPTION AND OVER THE COUNTER MEDICATION REQUEST: LONG TERM
School Year 2024-2025

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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