Requirements for administration of

Prescription Medication

Reference: ARS 15-344

Student Name:		/ - - /	
Last	First	Student's Birthdate	Grade for 2011-2012

Dear Parent/Guardian:

You **MUST** read the Medication Distribution section of your current Policy Handbook. No medication will be distributed by any CCS personnel unless the legal and required procedures are followed by the parent/guardian. These procedures are available in your handbook. Some of the requirements involve your doctor and pharmacy's involvement so read them PRIOR to receiving the prescription to ensure you have all that is needed in order for the school to assist you!

I hereby request and give my consent for the school nurse or person designated by the principal to see that my child receives the following prescribed medication. This medication is to be furnished by me in the original container and is to be labeled with and given in the following manner:

Name of medicine:	
Physician's Name (Must be on the label):	
Prescription Number:	
Reason for Medication:	
Route of administration (By mouth, etc.):	
Time of day to be taken:	
Duration of treatment:	

I authorize the school nurse/health aid or designee to be my agent to give to my child the medication that I have provided to the school and noted above.

____/_______________

Signature of Parent/Guardian **Date**