# **HEALTH SERVICES**

# Cherie Gaither, DNP, RN

# Director of Health Services

(520) 269-4510 • FAX (520) 269-4513



 Susan Zibrat Deanna M. Day, M.Ed. Scott K. Baker, Ph.D. Vicki Cox Golder Matthew A. Kopec

 President Vice President

Governing Board Members

 701 W. Wetmore Road • Tucson, AZ 85705 • (520) 696-5000 • www.amphi.com

Superintendent

Todd A. Jaeger, J.D.

**Medication Permit**

Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Route\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time(s) to be given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_as prescribed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daily \_\_\_\_\_\_\_\_\_\_\_ or As Needed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the School Nurse, Health Aid, Health Assistant, (may include substitute) or principal designee to give the above medicine.

I authorize persons designated for field trips AMPHI employee or principal’s designee to be my agent to give the above medication to my child.

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**

 **I give permission to my child to self-carry/administer the above medication.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Signature – for self-carry/administration or injections Date**

**(exceptions - diabetic, anaphylaxis, asthma supplies/medications**

**I give the School Nurse permission to discuss my child’s medication with the above named Physician.**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**

**Parent Instructions & Statement of Understanding**

1. The medication is to be furnished by parent or legal guardian and is to be labeled in the original prescription bottle, with the student’s name, name of medication, dosage (amount given), time of day to be given, and name of Physician.
2. The School Nurse must be notified by the primary care provider of any changes in medication, dose or time to be given.
3. In absence of the School Nurse, a District employee who has been designated by the parents as their agent (see above) may administer the medicine. This agent is performing a ministerial function only. Under no circumstances may non-nurse personnel administer a medication to a student if nursing judgment is required for proper administration. (see Amphi Board Policy JLCD)
4. The parent agrees to provide an extra properly labeled prescription bottle when needed for field trips. If an extra prescription bottle is not provided, health office staff will send the school bottle with its entire contents unless other arrangements are made.
5. End of the year medications will be discarded if not picked up.

**I have read and understand the Statement of Understanding.**

 **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Parent/Guardian Signature Date**