ARIZONA AUTISM
CHARTER SCHOOLS, INC.

Medication Administration in School 2019-20

Child's Name:		Date of Birth:
Name of Medication:	**Dosage:**	**Time:**

I request that authorized school staff give my child the medication noted above, according to the Heath Care Provider's signed instruction on the lower part of this form.

The School agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication. The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription Medications: must come in a container labeled with child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the Counter Medication: must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the school staff delegated to administer medication.

SIGN HERE

Parent/ Legal Guardian Name _____ **Signature** _____ **Date** _____

Work Phone _____ **Cell Phone** _____

Health Care Provider Authorization to Administer Medication in School

Child's Name:	DOB:
Medication:	
Dosage:	**Route:**
To be given at the following time(s):	
Special Instructions:	
Purpose of medication:	
Side effects that need to be reported:	
Start Date:	**End Date:**

SIGN HERE

Signature of Health Care Provider with Prescriptive Authority _____ **License Number** _____

Phone Number_____ ***Date***_____

Please ask the pharmacist for a separate medicine bottle to keep at school. Thank you!