Arizona Department of Health Services
Bureau of Child Care Licensing

MEDICATION CONSENT FORM

First & Last Name of **CHILD**:			
Type/Name of Medication:	Prescription #:	Dosage:	Route (method)*:
Start date:	End Date:	Times & frequency:	
REASON:			
I give permission for the administration of the medication, according to the instructions listed, to the child listed above.			
Date of authorization:	Signature (parent/guardian):		

POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION:

_____

_____

* Injections: Attach health care provider's written authorization.

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FOR STAFF REVIEW PRIOR TO ADMINISTERING MEDICATION:	YES	NO
Is the medication consent form complete?	☐	☐
Is the original prescription label on the medication container or prepackaged and labeled for use by manufacturer?	☐	☐
Is the full name of the child on the container?	☐	☐
Is the prescription or over-the-counter medication current?	☐	☐
Is the dose, name of drug, frequency of administration given on label consistent with instructions above?	☐	☐

Staff initials:_____

Please use the second page to document administration of the medication.

PAIDEIA ACADEMIES

Request For Administration of Medication At School

Student: _____ Birth Date: _____

School: _____ Teacher: _____ Grade: _____

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Medication 1	Medication 2
Medication name: _____	Medication name: _____
Reason for Medication: _____	Reason for Medication _____
Dose: _____	Dose: _____
Method of Administration: _____	Method of Administration: _____
Time of Administration: _____	Time of Administration: _____
Start: ☐ Immediate ☐ Other Date: _____	**Start:** ☐ Immediate ☐ Other Date: _____
Stop: ☐ End of Year ☐ Other Date/Duration _____	**Stop:** ☐ End of Year ☐ Other Date/Duration _____
☐ For Episodic/emergency events only	☐ For Episodic/emergency events only
Restrictions and/or important side effects	Restrictions and/or important side effects
☐ None anticipated	☐ None anticipated
☐ Yes, Please describe: _____	☐ Yes, Please describe: _____
Special Storage Requirements: ☐ Refrigerate ☐ None	Special Storage Requirements: ☐ Refrigerate ☐ None

Health Care Provider's Signature: _____ Date: _____

Phone# _____ Address: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

PARENTAL CONSENT FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

Parent(s)/guardian(s) of _____, request that medicine be administered by the school nurse or a member of the school staff if the school nurse is not available. I consent to allow disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel. I will notify the school if the medication has changed or is no longer needed. Medication will be furnished in its pharmacy-labeled container. I understand that this medication will be destroyed if it is not claimed within one week following the termination of the physician's authorization or one week beyond the end of the school year.

Parent/Guardian: _____ Date: _____

Day Time Phone #: _____ Address: _____

Principal _____ Date: _____

School Nurse _____ Date: _____

This request **MUST** be updated annually.