EDUPRIZE SCHOOLS

Gilbert Campus
580 W. Melody Ave.
Gilbert, AZ 85233
480-813-9537
480-813-6742 fax

Queen Creek Campus
4567 W. Roberts Rd.
Queen Creek, AZ 85142
480-888-1610
480-888-1655 fax

PRESCRIPTION AND NON-PRESCRIPTION MEDICATION CONSENT

☐ Please check here if NON-Prescription

I the Parent/Guardian, hereby request and give my consent for the designated school staff member or administrator to see that my child, _____, receives the medication prescribed by (medical provider) _____ for Diagnosis/Condition _____.

The medication is to be furnished by me in the original labeled container, and given in the following manner:

1. Name of the medication _____
2. Strength of medication _____
3. Dosage (amount to be given) _____
4. Approximate time of administration _____ Don't give after (time) _____
5. Route of administration (by mouth, topically, etc.) _____
6. Date medication is to be discontinued _____

Healthcare Provider's Name: (printed) _____ Phone No. _____

Healthcare Provider's Name: (Signature) _____ Date _____

I am aware that medications, <u>except that pertain to life threatening conditions</u>, <u>WILL NOT</u> be sent during a school designated field trip unless requested by parent at least 48 hours in advance of EACH field trip.
(Initial) _____

When deemed necessary, non-prescription medications will be administered with signed consent. Non-prescription medication given beyond 3 consecutive days, will need a medical provider's order to insure that this medication is not masking any underlying symptoms of a serious condition in the student.
(Initial) _____

I understand that I will be given notification regarding medication expiration. If no response is received or the medication is not replaced, this consent may be terminated by EDUPRIZE Health Office Staff and the medication discarded.
(Initial) _____

I understand that unless I have made previous arrangements with the EDUPRIZE Health Office Staff, any medication left in the Health Office after the last day of school, will be discarded.
(Initial) _____

Parent/Guardian Signature: _____ Date: _____

Teacher Name: _____

DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY

Medication returned to parent/guardian or discarded on (date) _____

Parent/Guardian Signature _____ Self Carry Y __ N __

EDUPRIZE Nurse Signature _____ Chamber/Spacer Y __ N __