Elgin School
(520) 455-5514
Sonoita School District #25, 23 Elgin Road, Elgin AZ 85611

Request for Medication at Elgin School

School Year: ________________

Name: ______________________________ Parent/Guardian Name: ________________________

Grade: ____________________________ Teacher: __________________________________

Medication: _____________________________________ Dosage: ______________________

Reason: ___________________________ Time to Be Given: ___________ ❑ AM ❑ PM or ❑ As Needed

From (Date) ______________________ To (Date) ______________________

Medication is Over-The-Counter/Store Purchased ❑

Prescriber's Name: ______________________________ Prescriber's Phone #: ____________________

Known Medication or Food Allergy to:____

I hereby request and give my consent for the school nurse or person designated by the administrator to give the above named medication to my child. This request includes authorization for the school nurse to contact the health care prescriber when necessary. I agree to notify the school nurse immediately in writing of any changes in medication, dose, or time of day for the administration.

Parent/Guardian Signature: ___________________________________ Date: ____________________

This Consent is Good for the Current School Year Only.

Prescription medication must be in the original container as prepared a pharmacist and labeled to include the patient name, name of medication, dosage, and time to be given. Please ask for an extra bottle for school use. An over-the-counter medication must be in the original packaging, with all directions, dosages, compound contents, and proportions clearly marked.

Medication Count: ________ Date: ___________ Parent Signature: ____________________ Nurse/Designated Staff Signature: ____________________

Medication Count: ________ Date: ___________ Parent Signature: ____________________ Nurse/Designated Staff Signature: ____________________

Medication Count: ________ Date: ___________ Parent Signature: ____________________ Nurse/Designated Staff Signature: ____________________

Medication Count: ________ Date: ___________ Parent Signature: ____________________ Nurse/Designated Staff Signature: ____________________

Medication Count: ________ Date: ___________ Parent Signature: ____________________ Nurse/Designated Staff Signature: ____________________

Unlicensed Assistive Personnel Documentation

Date	Time	Medication/Dose	Route	Signature	Comments

Dated 5/22/2023