DEER VALLEY
Unified School District

Medical Authorization to Administer Medication or Dietary Supplement to Student and Authorization for Release of Health Information

Health Care Provider Order for School to Administer Medication (prescribed) or Dietary Supplement.

I request the following student be given medication at school because I believe there exists a valid health reason which necessitates medication administration during the school day.

_____ _____
Student Name **Birthdate**

_____ _____
Medication #1 **Time to be administered at school**

_____ _____
Condition being treated **Dosage and mode of administration.**

_____
Side Effect to be expected, if any. (What emergency measures should be taken if this occurs?)

_____ _____
Medication#2 **Time to be administered at school**

_____ _____
Condition being treated **Dosage and mode of administration.**

_____
Side Effect to be expected, if any. (What emergency measures should be taken if this occurs?)

_____
Other medications the School should be aware of.

_____ _____
Health Care Provider Name (Printed) **Health Care Provider Signature**

_____ _____
Address **Date**

_____ _____ _____
Telephone **Fax** **Email**

Parent agrees that the school nurse may contact physician with questions regarding the above medication and possible side effects as needed and the exchange of medically necessary information between both Health Care professionals.

_____ _____
Parent Signature and Printed Name **Date**

6/1/18
jd