DEER VALLEY
Unified School District

Date:

Dear Parents/Guardian,

In accordance with the Arizona School Board Association and the DVUSD Governing Board Policy JLCD, concerning administration of medication at school, there is a requirement in order to give prescribed medications and dietary supplements in the school setting.

A written doctor's order will be required per Governing Board Policy JLCD "Medicines/Administering Medicines to Students".

"There shall be a written order from the physician stating the name of the medicine, the dosage, and the time it is to be given." The prescribing physician must renew this order each school year.

We have prepared a form for you to take to your physician to complete and return to the School Nurse. No prescription medication or dietary supplement will be given without the written orders from your prescribing physician or other qualified health care professional. This form can be obtained from your school nurse.

This requirement is in addition to the Parents Request for Giving Medication at School Form and will be enforced at the beginning of each school year. All other requirements remain in accordance with DVUSD School policy.

If you have any questions you may contact your school nurse.

Sincerely,

Nurse Christy

School: Mirage Elementary

Phone: 602-467-5310

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.

This Order Good for School Year: _____

_____ _____
Student Name **Birthdate**

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

_____ _____
Condition being treated (Include ICD 10 Code) **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 (Include ICD 10 Code) **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**

School Nurse | **Phone No.** | **Fax No.** |

_____ _____
School Nurse Signature **Date**

02/25/22 jd