ARIZONA ARTS ACADEMY

PHYSICIAN'S ORDER FOR MEDICATION AT SCHOOL

Student Name (printed): _____ Date of Birth: _____

Medication is ordered to be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the medication will be dispensed by designated school staff if the school nurse is not present. The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

Will this medication be dispensed during school hours? ☐ Yes ☐ No
If yes, give diagnosis and reason: _____

Medication name: _____ Time to be given: ☐ Lunch ☐ Hour _____ ☐ As Needed

Dose to be given: _____ Dosage form: _____ Mode of administration: _____

Duration without subsequent order: ☐ Weeks _____ ☐ Months _____ ☐ School Year _____ ☐ Other: _____

_____
Health Care Provider Name/Stamp (printed) Phone Fax

_____
Health Care Provider Name (signature) Email Date

********** **THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY** **********

Parent/Guardian's Permission

I request that the school nurse or designated Arizona Arts Academy staff member be permitted to dispense to my child, *(Name of Child)* _____, the medication prescribed by *(Name of Physician)* _____ for a period from _____ to _____.

The medication is to be furnished by me in the original container labeled by the pharmacy. The pharmacy label should include the name of the student, the name of the medication, the name of the prescribing physician, the dosage amount to be taken, and the time of day to be taken.

I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions. I request that the school nurse or designated staff be permitted to discuss my child's medical issues with healthcare providers and administer the medication to my child.

This authorization is good for the _____ school year only.

_____
Parent/Guardian Name (printed) Date

_____
Parent/Guardian Name (signature) Contact Number Email Address

9502 S Hwy 92, Hereford, AZ 85615
520-210-5400 Call or Text
Email: admin@azarts.academy

106 Howard St., Huachuca City, AZ 85616
520-210-5400 Call or Text
Email: admin@azarts.academy

226 Hwy 70, Pima, AZ 85543
928-485-4546 Call or Text
Email: admin.gv@azarts.academy