VERITAS PREPARATORY ACADEMY
A Great Hearts Academy
3102 North 56th Street, Suite 100 | Phoenix, AZ 85018 | Office: (602) 263-1128 | Fax: (602) 263-7997 | www.veritasprep.org

Medical Information and Consent to Dispense Medications – School Year 2018-2019

Student Name: _____ Birthdate: _____

Known Allergies: _____

Medical Concerns/Conditions: _____

Prescription Medication – Medications must be furnished by the parent/guardian in the original pharmaceutical container with affixed prescription label and written dosage instructions from the prescribing physician/healthcare provider. No more than a 30 day supply of medication should be brought to the health office. All medication should be brought to and taken from the health office by a parent/guardian. _____ Parent/Guardian initials

Name of Medication	Route to be taken	Dosage amount	Time	Expected duration	Indication for treatment	Prescriber's name	Possible side effects

Non-Prescription (Over-the-counter) Medication – All medications must be furnished by the parent/guardian in the original, unopened, small-sized pharmaceutical container accompanied by a physician's order with written dosage instructions. Expired medication not picked up within 10 days of notification, and all medication at the end of the school year, will be disposed of in accordance with federal guidelines. Expired medication or medication without proper dosage instructions will not be administered to students. All medication must be brought to, and taken from the health office by a parent/guardian. _____ Parent/Guardian initials

Name of Medication	Route to be taken	Dosage	Time	Expected duration	Possible side effects

Special requirements for medication (i.e. take medication with food): _____

Please note the school health office does not provide over-the-counter medications. First aid items such as band aids are kept to a minimum and **do not** include Tylenol, Motrin, Midol, antacids, contact lens cleaning solutions, etc. If your student needs such items, please provide them using this form and in the smallest possible container within the guidelines provided.

Healthcare Provider Name: _____ Phone: _____

I hereby authorize any hospital/doctor/emergency personnel to render immediate aid as might be required at the time for the health of the above named student. I understand that I am responsible for any expenses these services may incur and accept full financial responsibility. In the event my child needs to be hospitalized, emergency paramedics have my permission to take my student to the closest emergency hospital facility.

_____ Date: _____

Parent/Guardian Signature