Sequoia Pathway Academy
19265 N. Porter Rd
Maricopa, AZ 85138

STUDENT NAME: ___________________________ DOB:_________ Grade :_________
PARENT NAME: ____________________________ HOME PHONE: _________________________
STUDENT ALLERGIES: _______________________ CELL#: _________________________________

I hereby request and give consent for (School) to administer the following medication to my child.

All Medication must be in the **ORIGINAL CONTAINER**, this includes over the counter medication. Your pharmacist will provide you with a separate bottle for school. Your child's medication will be given exactly as the direction on the bottle indicates.

While we realize that it is often an inconvenience to bring the medication to the Health Office, please be aware that;

ACCORDING TO THE ARIZONA DEPARTMENT OF HEALTH, CHILDREN CANNOT CARRY MEDICATION TO AND FROM SCHOOL. MEDICATION MUST ALWAYS BE BROUGHT IN BY PARENT OR GUARDIAN TO THE HEALTH OFFICE.

Medication:____ **Dosage:**___________
Diagnosis:___________________________________ **Prescribed by:**________________________
Med Description:______________________________ **Time:**________________

DATE	# Pills Received	Parent Signature	School Rep. Signature	#Pills Returned	DATE	Parent Signature	School Rep. Signature

NOTES:

Over→

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NOTES: