



Medicine Authorization Form

Birth Date: ___/___/___

Student Name: _____

Grade for 10-11: _____

Special Medical Conditions

Please list any allergies (foods, pollen, medications,...)

Please list any medical conditions your student has (asthma, diabetes, epilepsy, ADD, ADHD,...)

Please list any eye conditions (near sighted, far sighted, contacts, glasses,...)

Please list any medications taken:

In case of minor accident or illness during the school day, I authorize the school nurse or designee to administer the over-the-counter medications and dosages indicated below (not to exceed one dose per day):

Parent signature _____ Please initial the medications and indicate the dosages your child may receive:

- | | |
|--|---|
| _____ Adult Tylenol (Acetaminophen) 325 mg./tablet | _____ Number of tablets |
| _____ Children's chewable Tylenol (Acetaminophen) 80 mg./tablets | _____ Number of tablets |
| _____ Children's Tylenol Elixir (Acetaminophen) 160mg./teaspoon | _____ Number of teaspoons |
| _____ Adult Motrin (Ibuprofen) 200 mg./tablet | _____ Number of tablets |
| _____ Children's Motrin Elixir (Ibuprofen) 100mg./teaspoon | _____ Number of teaspoons |
| _____ Benadryl Liquid (Antihistamine) 12.5 mg./teaspoon | _____ Number of teaspoons |
| _____ Cough drops with Menthol Eucalyptus as needed. | _____ Eye drops (artificial tears) as needed. |
| _____ Tums Antacid (generic) _____ Number of tablets. | _____ Student's Estimated Weight (lbs.) |



Medicine Authorization Form

Birth Date: ___/___/___

Student Name: _____

Grade for 10-11: _____

Special Medical Conditions

Please list any allergies (foods, pollen, medications,...)

Please list any medical conditions your student has (asthma, diabetes, epilepsy, ADD, ADHD,...)

Please list any eye conditions (near sighted, far sighted, contacts, glasses,...)

Please list any medications taken:

In case of minor accident or illness during the school day, I authorize the school nurse or designee to administer the over-the-counter medications and dosages indicated below (not to exceed one dose per day):

Parent signature _____ Please initial the medications and indicate the dosages your child may receive:

- | | |
|--|---|
| _____ Adult Tylenol (Acetaminophen) 325 mg./tablet | _____ Number of tablets |
| _____ Children's chewable Tylenol (Acetaminophen) 80 mg./tablets | _____ Number of tablets |
| _____ Children's Tylenol Elixir (Acetaminophen) 160mg./teaspoon | _____ Number of teaspoons |
| _____ Adult Motrin (Ibuprofen) 200 mg./tablet | _____ Number of tablets |
| _____ Children's Motrin Elixir (Ibuprofen) 100mg./teaspoon | _____ Number of teaspoons |
| _____ Benadryl Liquid (Antihistamine) 12.5 mg./teaspoon | _____ Number of teaspoons |
| _____ Cough drops with Menthol Eucalyptus as needed. | _____ Eye drops (artificial tears) as needed. |
| _____ Tums Antacid (generic) _____ Number of tablets. | _____ Student's Estimated Weight (lbs.) |

IMMUNIZATION REQUIREMENTS

Children must have proof of all required immunizations, or valid exemption, in order to attend the first day of school. Arizona law allows exemptions for medical reasons, laboratory evidence of immunity and personal beliefs. Exemption forms are available in the school office. The record for each vaccine dose must include the date and name of doctor or clinic. This document must show the date and type of each dose administered. Copies of any of the above documented proofs of immunization are also acceptable. If you do not have documentation of your child's immunizations, you may need to obtain laboratory evidence of immunity. If you have any questions, please call PVC at 602 992-8140. We will be glad to assist by making copies of any of your child's immunization records.

I, _____ (Print Name) have read and understand the above information and have turned in proof of the required immunizations on ____/____/____ (Date).

I, _____ (Print Name) have read and understand the above information and will turn in proof of the required immunizations on ____/____/____ (Date) prior to attendance of my student.

Parent's Signature

Date

6/09

IMMUNIZATION REQUIREMENTS

Children must have proof of all required immunizations, or valid exemption, in order to attend the first day of school. Arizona law allows exemptions for medical reasons, laboratory evidence of immunity and personal beliefs. Exemption forms are available in the school office. The record for each vaccine dose must include the date and name of doctor or clinic. This document must show the date and type of each dose administered. Copies of any of the above documented proofs of immunization are also acceptable. If you do not have documentation of your child's immunizations, you may need to obtain laboratory evidence of immunity. If you have any questions, please call PVC at 602 992-8140. We will be glad to assist by making copies of any of your child's immunization records.

I, _____ (Print Name) have read and understand the above information and have turned in proof of the required immunizations on ____/____/____ (Date).

I, _____ (Print Name) have read and understand the above information and will turn in proof of the required immunizations on ____/____/____ (Date) prior to attendance of my student.

Parent's Signature

Date

6/09