Albemarle County Public Schools
Parent's Request for Giving Medicine at School

School	Phone	Fax	School	Phone	Fax
Agnor-Hurt	973-5211	974-7046	Stony Point	973-6405	973-9751
Baker-Butler	974-7777	964-4684	Woodbrook	973-6600	973-0317
Broadus Wood	973-3865	973-3833	Burley	295-5101	984-4975
Brownsville	823-4658	823-5120	Henley	823-4393	823-2711
Crozet	823-4800	823-6470	Jouett	975-9320	975-9325
Greer	973-8371	973-0629	Lakeside	975-0599	975-0852
Hollymead	973-8301	978-3687	Walton	977-5615	296-6648
Meriwether Lewis	293-9304	979-3850	Albemarle	975-9300	974-4335
Mountain View	293-7455	293-2067	Monticello	244-3100	244-3104
Murray Elem.	977-4599	979-5416	Murray High	296-3090	979-6479
Red Hill	293-5332	293-7300	Western Albemarle	823-8700	823-8711
Scottsville	286-2441	286-2442	Learning & Growth	974-8070	979-6479
Stone Robinson	296-3754	296-7645	Center 1	244-8900	

Parent's Request for Giving Medicine at School

Please send this form to the school when needed. All areas on this form must be completed for school staff to administer the medication. Please print.

Please have the school nurse, or a member of school staff, administer to: _____
the following medication: (name of child)

(Check one) _____ Certain prescription medication specified below or

_____ Non-prescription medication specified below.

I understand that the person at the school who will administer this medication or treatment may be inexperienced and untrained in this requested service and state, without reservation, that I shall not hold him/her or the Albemarle County School Board liable in any way for harm or injury that may be experienced by my child as a result of this service. **I understand I am to provide all medication administered to my child in its original container.** I realize medical information associated with the use of this medication may be disclosed to school employees with supervisory authority for my child. For prescription medication, my signature below shall be deemed consent for the school nurse to contact the physician named below for signature or to discuss the medication.

Date of Order: _____ Name of medication: _____

Exact dosage to be given: _____ Time of day to be administered: _____

Reason for medication: _____

Duration for medication: _____

Special Instructions: _____

_____ _____ _____
Signature of Physician/Date (for prescription medication) | Name of Parent | Home Telephone

_____ _____ _____
Physician telephone (for prescription medication) | Signature of Parent or Guardian/Date (for all medication) | Daytime Telephone

Student's Date of Birth: _____

PLEASE NOTE THAT FEVER LOWERING MEDICATION SUCH AS IBUPROFEN OR TYLENOL WILL NOT BE ADMINISTERED WITHOUT A PHYSICIAN'S AUTHORIZATION DURING THE PANDEMIC

07/19/21