Richmond County Public Schools
P. O. Box 1507
Warsaw, Virginia 22572
804-333-3681

Richmond Co. Elementary/Middle Schools
361 Walnut Street
Warsaw, VA 22572
804-333-6229, 804-333-6274

Rappahannock High School
6914 Richmond Road
Warsaw, VA 22572
804-333-6264

MTL Center
13027 History Land Hwy
Warsaw, VA 22572
804-333-6200

Medication Policy and Medication Permission Form
For School Year _____

Medication Policy

1. For medications to be administered at school, a **Medication Permission Form** (below) must be completed by the parent/guardian and the physician**. Prescription medications must have a physician's authorization**.
2. Over-the-counter medications can be administered for five days with a parental note. After five days a physician's authorization must be obtained.
3. Medication **must** be brought to school in the **current original container** as dispensed by the pharmacist or physician. Students transporting medication to school must report to the clinic upon arrival. Students are not permitted to carry or self-administer any medication while at school unless written authorization by the physician.
4. Medication not used for 30 days will be destroyed, except for asthmatic medications and Epi-Pens.
5. All medications and equipment must be picked up during the last day of the school year. After the last school day, all remaining medications will be properly destroyed.
6. The school does not furnish any medication.
7. **It is the responsibility of the parent/guardian to have the medication permission form(s) completed. Medication permission form(s) will no longer be faxed to the physician's offices. Original form(s) are to be returned to the appropriate school.**

Medication Permission Form Drug Allergies: _____

Student's Name: _____DOB:_____

Name of Medication: _____
_____

DIAGNOSIS + ICD-10 Medication Purpose: _____

Medication Dosage and Time: _____ Duration of Medication: _____

I certify that it is **medically necessary** (**morning medications**) for the above-described medication to be administered to my child during the _____ school year. The **morning medication** needs to be administered during regular school hours for the stated reason written below:

_____

Please Print Name of Physician: _____, MD

Signature of Physician: _____, MD

Date: _____

I, the parent/guardian, give my permission for _____ to take the above-prescribed medication at school. I understand that the school nurse, the principal, or his designee may administer this medication. I have read and understand items 1-7.

Signature of Parent/Guardian: _____ Date: _____