

## **MEDICATION REQUEST FORM**

## THE SCHOOL ASSUMES NO RESPONSIBILITY FOR NON-MEDICALLY PRESCRIBED MEDICATION OR MEDICATION ADMINISTERED BY THE PUPIL HIMSELF.

No medication will be administered unless:

- 1. There is a Medication Request Form signed by a Physician/Nurse Practitioner yearly or when there is a medication change.
- 2. This form is signed by the parent and nurse of the school.
- 3. The medication is presented by the parent/guardian to the school nurse, principal or designee.
- 4. The medication is in the original container.

## MEDICATION CANNOT BE TRANSPORTED ON THE SCHOOL BUS OR BY ANY CHILD. PARENTS/GUARDIANS MUST BRING IN MEDICATION TO THE SCHOOL NURSE.

## TO BE COMPLETED PHYSICIAN/NURSE PRACTITIONER

| Name of Student:                                                                                                                                                                                                                     | Date of Birth:          | Grade:                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------|
| Address:                                                                                                                                                                                                                             | ·                       |                                            |
| School:                                                                                                                                                                                                                              |                         |                                            |
| Diagnosis:                                                                                                                                                                                                                           |                         |                                            |
| Medication/Treatment Required:                                                                                                                                                                                                       |                         |                                            |
| Dosage:                                                                                                                                                                                                                              | Route:                  | Time/Schedule:                             |
| Side effects, precautions, special instructions or comments:                                                                                                                                                                         |                         |                                            |
| I have examined the above child and determine that the abo                                                                                                                                                                           | ve medication is medica | ally necessary during school hours.        |
| Physician/Nurse Practitioner Name (Please Print):                                                                                                                                                                                    |                         |                                            |
| Address:                                                                                                                                                                                                                             |                         |                                            |
| Telephone:                                                                                                                                                                                                                           | Fax:                    |                                            |
| Physician/Nurse Practitioner Signature:                                                                                                                                                                                              |                         |                                            |
|                                                                                                                                                                                                                                      | OF PARENT/GUAR          | DIAN                                       |
| <b>TO BE COMPLETED BY Parent/Guardian</b><br>I am unable to personally administer the above medica<br>do so. I request, and hereby authorize, the school to a<br>exchange of information between the physician/nurse  <br>treatment. | administer the above i  | medication as prescribed. I consent to the |
| Signature of Parent/Guardian D                                                                                                                                                                                                       | ate                     |                                            |

Home Telephone #

Work Telephone #

Cell Phone #

Nurse Signature

Date

The Orange County School Board does not discriminate on the basis of race, color, creed, religion, national origin, ancestry, political affiliation, sex, sexual orientation, gender, gender identity, age, pregnancy, childbirth or related medical conditions, marital status, status as a veteran, genetic information, disability, or any other characteristics protected by law in its employment practices or educational program and activities. Compliance inquiries should be directed to the Director of Human Resources, 200 Dailey Drive, Orange, VA 22960 or by phone at 540-661-4550.