Revised 10/2020
Request for Medication to be Given During School Hours

Location of Medication	Medication Expiration Date	Amount Received

Note to Parents/Guardians:
Alleghany County Schools require that all students who need medication during school hours must:

1. Present this completed form
2. Prescription medicines must be brought to school by an adult in a pharmacy-labeled bottle which contains instructions on how and when the medicine is to be given. (Parents may request the pharmacist dispense two bottles of medication, one for home and one for school.)
3. Over-the counter drugs must be received in the original container and will be administered according to the doctor's written instructions.

Medication may be given by school personnel provided the physician completes this medication permission request form. Medication should be brought to school by parents rather than children.

Name of Student: _____ School: _____ Teacher: _____

To Be Completed by Physician/Only one medication per medication sheet

Medication: _____Dosage: _____

Time(s) to be given at school: _____ Length of time: _____

Check form of medication: ☐Tablet ☐Capsule ☐Liquid ☐Ointment ☐ Inhalant ☐Other

Emergency Medications (ONLY Inhalers, Epi Pens, and Glucagon) may be kept on student: ☐ yes ☐ no

Precautions/Side Effects/Comments:

_____

Physician's Signature: _____ Date: _____

Parent's Permission

I give my permission for my child to receive medication during school hours as prescribed by a physician. I hereby release the School Board, their agents, and employees from any and all liability that may result from my child taking the prescribed medication. I understand that any discontinued or unused medication will be disposed of at the end of the school year. If a Care Plan is needed for my child, I will be asked to complete one. If the Care Plan is not returned completed, the nurse may complete one and give to staff on a need to know basis.

Parent Signature: _____ Date:_____ Telephone #: _____

School Use Only **Reviewed by: School Nurse**_____

RETURN TO SCHOOL NURSE

ATTACH PHOTO

DAILY MEDICATION ADMINISTRATION FOR SCHOOL YEAR

STUDENT		TEACHER	

Medication/Dose/Time	Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Aug																															
	Sept																															
	Oct																															

Medication/Dose/Time	Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Nov																															
	Dec																															
	Jan																															

Medication/Dose/Time	Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Feb																															
	March																															
	April																															

Medication/Dose/Time	Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	May																															
	June																															
	July																															

CODES	SIGNATURE & INITIAL of those AUTHORIZED TO ADMINISTER MEDICATIONS			
Medication given Initial				
Student Absent A				
No Show NS				
Late L				
Field Trip FT				
Medication Out MO				

MEDICATION DATE/NAME/AMOUNT BROUGHT IN

DATE	NAME OF MEDICATION	AMOUNT	DATE	NAME OF MEDICATION	AMOUNT	DATE	NAME OF MEDICATION	AMOUNT

MEDICATION NAME	DATE DISCARDED	HOW DISCARDED	TWO SIGNATURES