Physician's Request and Parent Permission for Administration of Medication

Administration of medications will be permitted on school property only when medically necessary and under direct supervision of appropriate staff members. Administration of medication during school hours is discouraged; however, individual needs will be taken into consideration. For the safety of the students, the following guidelines must be enforced.

1. A written request using this form from a physician/practitioner detailing the **prescription** drug and the specific information below is required.
2. The prescription medication is to be brought to the school by the parent/guardian in the original container which is correctly labeled by the pharmacist with the name of the student, the name of the medication, dosage, name of physician, and time to be given.
3. Over the counter medications must be delivered by the parent/guardian in the original, unopened container. This form is completed but does not require physician's signature.

   Herbal remedies and over-the-counter supplements that are not approved by the FDA require a written order from a physician/practitioner
4. Written parent/guardian permission is required to administer any medication.
5. Any change of prescription requires a new written order from the prescriber. Schools are accessible by secure FAX for quick communication.

Section I: To Be Completed by Parent

Student's Name _____ Grade _____ Date of Birth_____

Address_____

I hereby request that my child be given the medication named below while in school and away from school for official activities. I understand that the medication may be given by trained non-medical personnel. I give my permission for appropriate personnel to communicate with my child's physician in matters related to medication and health supervision. I understand and agree that the School Board of the County of Roanoke, its officers, agents, and employees are not responsible for the effects of the medication administered.

I understand that I must notify the school of any changes in my child's condition, medication, or dosage. I further understand that I am responsible for ensuring the medication safely arrives at school and for getting refills of the medication as indicated.

I do ___ do not___ request that the designated school personnel give the above medication on school days of early dismissal/late schedule.

Parent/Guardian Name (Print)_____ Daytime Phone No._____

Parent/Guardian Signature _____ Date_____

Section II: To Be Completed By Physician/Practitioner for prescription drugs and a Parent for OTC drugs

Name of Medication _____ Dose_____

Times of Administration_____

Reason for Medication Administration_____

Beginning Date for Administration _____ Ending Date_____

Possible Side Effects / Special Instructions or Precautions_____

_____

Trained, unlicensed assistive personnel (UAP) may administer ☐ Insulin ☐ Glucagon ☐ EpiPen/Epinephrine
(select all that apply)

(for prescription drugs)
MD/NP/PA Signature_____ Date _____

Printed Name_____ NPI#_____ Phone No._____

Student_____ DOB_____

Medication_____ Prescribed For_____

Time to be administered_____

20___/20___	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
August																															
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															

Code: A = Absent SC = School Closed LE = Leave Early H = Holiday R = Refused NS = No Show NM = No Medication

INSTRUCTIONS

1. School personnel administrating the medication should initial the appropriate box.
2. Sign full signature below (only once).
3. Use code to document reason for not giving medication.
4. If medication is given twice during one school day, document in one box.
5. If medication error or adverse reactions occur, complete the student accident report.

WEEKLY MEDICATION COUNT (Controlled Substances)

July						Jan					
Aug						Feb					
Sept						Mar					
Oct						Apr					
Nov						May					
Dec						June					

SIGNATURES
1.
2.
3.
4.
5.
6.

☐ Parent notified to pick up medicine at end of school year.

☐ Parent picked up medicine on _____ (date)

MEDICAL COUNT

Date	Number of Pills	Parent Initial	School Initial

_____ _____

Parent Signature School Signature