

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 _____ Teacher Ext: _____

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