RPS RICHMOND PUBLIC SCHOOLS

HEALTH SERVICES REGULATIONS ON MEDICATION ADMINISTRATION

REQUEST FOR MEDICATION/TREATMENT DURING SCHOOL HOURS
Medication will not be administered if this form is altered and/or is not filled out completely.

Richmond City Public Schools require that if medication/treatments are to be taken by a student while he/she is in school or participating in school activities, the school ***MUST*** have the following information completed and on file in the health clinic:
1. A signed order from the health care provider renewed yearly 2. A signed consent from the parent or guardian.
2. The medication in the original pharmacy container. THIS APPLIES TO ANY MEDICATION, PRESCRIPTION OR OVER THE COUNTER

All medication must be kept in the school health office. It is the responsibility of the student to come to the clinic for administration at the proper time. Student possession and self-administration of certain medications are permitted for conditions such as Diabetes, Asthma, and Allergy. More specific documentation from health care provider and supporting materials are required. Families should request an appointment with the school nurse in these cases.

To be completed by the Health Care Provider:

Student: _____ Grade: _____ School: _____
Medication/Treatment: _____ Dosage, Frequency, Route: _____ Diagnosis: _____
Medication/Treatment Required: School Year Short Term _____ Date required: _____ Special Instructions, Side Effects, Comments:
_____
_____
_____
HealthCare Provider Signature: _____ Health Care Provider PRINTED Name: _____ Address: _____ Telephone: _____ Fax_____
Date:_____

To Be Completed by Parent or Guardian:
I request that school personnel administer the above medication/treatment ordered by the health care provider, according to the directions provided. I understand that the nurse is not always available and that an appointed trained designee may be responsible for administering my child's medication/treatment. I authorize a representative of the school to share information regarding this medication/treatment with the above health care provider and school staff as necessary for the student's health and safety at school. I understand and agree to comply with the school's policies and procedures as stated on the back of this form.

Signature of Parent/Guardian _____ Date: _____

Revised 06/2021 Must be updated each school year