# STAFFORD COUNTY PUBLIC SCHOOLS HEALTH SERVICES

## Medication/Treatment Request

School Year: ___________

Stafford County Public School Board regulation 2602-R requires this form to be on file prior to any student receiving medication or prescribed treatments. This form is required for all medication, prescription and over the counter, and treatments to include the use of crutches, wheelchairs and other durable medical equipment. Alternative medications and treatments not approved by the US Food and Drug Administration for safety and effectiveness will not be administered in school.

1. Parent/Guardian or authorized adult must bring in all medications to the school clinic. Students may not deliver medications, to do so is in violation of the Student Code of Conduct.
2. Medications must be verified, counted, and documented by the school nurse or authorized designee.
3. All prescription medication must be in the original prescription bottle with pharmacist's label attached.
4. Over the counter (OTC) medication must be in the unopened original container with the manufacturer's dosage label and safety seal intact.
5. The first day's dose of any new non-emergency medication must be given at home before it can be administered at school.
6. Parent/Guardian is responsible for collecting any unused portion of a medication prior to the end of the school year, any unclaimed medication will be destroyed.

**PRESCRIBED MEDICATION/TREATMENT AUTHORIZATION- To be completed by prescribing healthcare provider**

Name of Student: ______________________________________________ DOB: ____________________

Reason for medication/treatment: ____________________________________________________________

Name of medication/treatment: ______________________________________________________________

Dosage: ________________ Time(s) to be given at school: ________________ Route: ________________

Duration: □ School Year □ Short Term (dates required) _____________

Special instructions, Side effects, Comments: ____________________________________________________

If PRN, specify when indicated (signs/symptoms): _________________________________________________

Frequency of administration (ranges not accepted, i.e. every 2-4 hours): _____________________________

I certify that, in my opinion, it is medically necessary that the medication/treatment described above be administered to the named student during school hours and is to be administered by the school nurse or authorized designee.

Authorized Prescriber's Name (print): ___________________________________ Phone: _______________

**TO BE COMPLETED BY PARENT/GUARDIAN**

I request that school personnel administer the above medication/treatment ordered by the healthcare provider, according to the directions provided. I authorize a representative of the school to share information/lab results regarding this medication/treatment with the above healthcare 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 regarding medication administration in school, related policies and procedures can be located on the Stafford County Public Schools website.

Parent/Guardian Signature: ____________________________________________ Date: _______________

**TO BE COMPLETED BY THE SCHOOL NURSE OR AUTHORIZED DESIGNEE- Attach documentation if applicable**

Check as appropriate:

- □ Medication section is complete, including signature of authorized prescriber. Authorization acceptable on prescription form/ office form.
- □ Prescribed medication is properly labeled and is consistent with prescriber's order. OTC medication is in an original, sealed container with manufacturer's label present.
- □ Parent/Guardian section is complete, including signature of parent/guardian.

Signature, School Nurse or Authorized Designee: ______________________________________ Date: ____________________

| Medication | Quantity | Drop Off/ Pick Up (circle) and Date | Signature- Nurse or Authorized Designee | Signature- Parent/Guardian |
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