FORM AAA-1075

CHESTERFIELD COUNTY PUBLIC SCHOOLS
STUDENT MEDICATION REQUEST (SMR)

To Be Completed by Parent or Guardian: (PLEASE PRINT)

NAME OF STUDENT:_____ DATE OF BIRTH: _____
LAST FIRST MIDDLE INITAL

PHYSICIAN/PHYSICIAN'S ASSISTANT/NURSE PRACTITIONER:_____

NAME OF MEDICATION:_____ EXPIRATION DATE OF MEDICATION_____

DOSAGE, ROUTE AND TIME OF ADMINISTRATION AT SCHOOL:_____

BEGINNING DATE:_____ ENDING DATE:_____

I, _____, parent or legal guardian of the above named student, request that this medication be administered to my child by designated school personnel, under the supervision of the principal, and in consultation with a school nurse or school nurse supervisor assigned by the Chesterfield County Public Schools.

I agree to furnish this medication in the original container with the label intact. I understand and accept that the Chesterfield County School Board, its employees, agents, or designees are not responsible for any effects of the medication administered when it is administered correctly as directed above.

I also agree to pick up any unused medication from the school clinic at the end of the school year. I understand that medication not picked up by parent or guardian at the end of the school year will be discarded.

_____	_____	_____	_____
Parent/Guardian (Print Name)	***Parent/Guardian Signature***	***Date***	***Phone Number***

FOR PARENTS OF STUDENTS WITH DIABETES: With parental consent and written approval from student's health care provider, student may carry and use diabetes supplies and self-check blood glucose levels. Refer to Diabetes Medical Management Plan for parental consent.

FOR PARENTS OF STUDENTS WITH ASTHMA AND/OR A LIFE-THREATENING ALLERGY (ANAPHYLAXIS), READ BELOW:
I give permission for my child to self-administer his/her auto-injectable epinephrine or inhaled asthma medication if so ordered by the licensed healthcare provider on the health plan, and the following conditions are met per Chesterfield County Public Schools' policy 4130:

1. Written permission from the parent that the student may self-administer auto-injectable epinephrine or an inhaled asthma medication must be on file with the school.
2. Written notice from the student's physician, physician's assistant or nurse practitioner must be on file with the school. The notice must indicate the student's name, diagnosis of asthma or anaphylaxis, approve the self-administration of auto-injectable epinephrine or inhaled asthma medication that has been prescribed for the student, specify the name and dosage of the medication, the frequency with which the medication is to be administered, and the circumstances that warrant use. The physician, physician's assistant or nurse practitioner must document the student's demonstrated ability to self-administer the medication safely and effectively.
3. An individualized health plan must be prepared, including emergency procedures, for any life-threatening conditions. Parents must disclose any relevant information regarding the health condition of the student to school personnel. Permission for a student to possess and self-administer auto-injectable epinephrine or asthma medication is effective for one school year and must be renewed annually.

_____	_____
Parent/Guardian Signature	***Date***

Medication received by _____ on _____
School Staff Member Name/Signature **Date**

Medication returned to parent/guardian by _____ on _____
School Staff Member Name/Signature **Date**

Parent/Guardian picking up medication: _____ on_____
Parent/Guardian Name/Signature **Date**

Reviewed 7/2016

FORM AAA-1075

CHESTERFIELD COUNTY PUBLIC SCHOOLS
STUDENT MEDICATION RECORD (SMR)
SCHOOL YEAR: 2016-2017

Student Name_____ Grade _____Date of Birth_____

Name of Medication:_____Expiration date of Medication: _____ Dosage, Route, Time:_____

Special Instructions:_____

Instructions: 1. Record time medication is given and initials of staff member administering medication. For medication prescribed for use **EVERY DAY**, an entry is required in each box. (See KEY below)
2. Record initials and signature of staff member administering medication at bottom of form
3. File form in student's educational record at the end of each school year. **FOR SCHOOL STAFF USE ONLY**

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
Sept.																															
Oct.																															
Nov.																															
Dec.																															
Jan.																															
Feb.																															
March																															
April																															
May																															
June																															

School Staff Administering Medication:

Initials and signature:_____
Initials and signature:_____
Initials and signature:_____
Initials and signature:_____
Initials and signature:_____

Comments:

KEY:

X: Not a school day	W: Withheld
N: No show to clinic	F: Field Trip
O: Out of medication	A: Absent
E: Early Dismissal	R: Refused
S: Self Administered	I: Inclement weather

Revised 7/2016