MEDICATION ADMINISTRATION CONSENT FORM
PRESCRIPTION/OVER-THE-COUNTER
POWHATAN COUNTY PUBLIC SCHOOLS

Student's Name: _____

Mailing Address: _____

Grade: _____ Date of Birth: _____

School: _____

I am the parent/guardian of _____. I give my permission for him/her to take the following medication while in school. I hereby acknowledge that I have read and understand the Medication Administration Policy for Powhatan County Public Schools. I authorize a representative of the school to share information regarding this medication with my child's physician and/or EMS personnel. I understand that school employees will administer my child's medication on field trips unless otherwise instructed by me.

_____ _____
Parent/Guardian Signature Date

_____ _____ _____
Home Phone# Work Phone# Cell Phone #

Medication: _____

Reason Given: _____

Dosage/Time Given: _____

Anticipated Length of Treatment: _____

Physician's Name: _____ Phone#: _____

A <u>PHYSICIAN'S WRITTEN STATEMENT</u> IS REQUIRED IN ORDER FOR PRESCRIPTION MEDICATIONS TO BE GIVEN AT SCHOOL. THIS STATEMENT SHOULD INCLUDE THE ABOVE INFORMATION AND MAY BE FAXED FROM THE PHYSICIAN'S OFFICE TO THE SCHOOL OR BROUGHT IN BY THE PARENT/GUARDIAN.

(Copies of the Medication Administration Policy are available in the clinics.)
(A separate form must be filled out for each individual medication.)
(A separate form must be filled out for each sibling in a family.)

<u>ANY UNUSED MEDICATION MUST BE PICKED UP BY THE LAST DAY OF SCHOOL. ANY MEDICATION NOT PICKED UP BY THE LAST DAY OF SCHOOL WILL BE DISCARDED BY CLINIC PERSONNEL.</u>

For clinic use only:

Date medication picked up: _____

Parent signature: _____

School nurse signature: _____