HANOVER COUNTY PUBLIC SCHOOLS
Authorization and Permission for Administration of Medication

Student: _____ DOB: _____ Grade: _____

- A medication administration form must be signed by a parent/guardian annually and immediately if changes occur.
- Non-prescription medication must be in the original manufacturer's container and be brought to the school by a parent/guardian.
- Prescription medications must brought to school by the parent in the current original properly labeled container as dispensed by the pharmacist or physician.
- Medication labels must contain the student's name, name of medication, directions for use and date. Physician's order and medication labels must agree.
- A physician, in writing, must authorize any medication, given for more than ten consecutive school days. The prescription label on the bottle will be accepted as the physician's order for those medications given for less than ten consecutive school days. SEE REVERSE SIDE FOR PHYSICIAN'S ORDERS.

TO BE COMPLETED BY PARENT/GUARDIAN

Medication: _____ Dosage (how much): _____

Time to be given: ❑as needed ❑other: _____

Reason for Medication: ❑headache ❑toothache/mouth pain ❑muscle pain ❑cramps ❑other: _____

Why do you need me to call you? ❑Emergencies only ❑No relief from medication ❑no medication available ❑other: _____

I request that the above listed student be administered medication at school by authorized staff, according to the prescription or medication instructions. The student has experienced no previous side effects from the medication. I further agree that the school personnel may contact the prescriber as needed and that medication information may be shared with authorized school personnel.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonable prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school, and to pick up remaining medication and equipment or it will be properly destroyed.

Signature Parent/Guardian _____ Date: _____

Address/ZIP _____

Phone: (H) _____ (W) _____ (C) _____

E-mail: _____

SEE REVERSE FOR PHYSICIAN ORDERS

TO BE COMPLETED BY PHYSICIAN

Student: _____ DOB: _____

Medication to be administered at school: _____

Dose: _____ Route: _____ Time: _____

Special Instructions: _____

_____

Possible Side Effects: _____

Start Date: _____ Discontinue Date: _____

M.D. Signature: _____ Date: _____

Printed Name _____ Phone: _____

TO BE COMPLETED BY SCHOOL PERSONNEL

Date	# Received/Returned	Signature/Co-Signature

Comments: _____

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