SPOTSYLVANIA COUNTY SCHOOLS

MEDICATION REQUEST FORM

_____

Name of School

THE SCHOOL ASSUMES NO RESPONSIBILITY FOR NON-MEDICALLY PRESCRIBED MEDICATION OR MEDICATION ADMINISTERED BY THE PUPIL HIMSELF.

No medication will be administered unless:

1. There is a Medication Request Form signed by a Physician/Nurse Practitioner yearly or when there is a medication change.
2. This form is signed by the parent and principal/designee of the school.
3. The medication is presented by the parent/guardian to the school nurse, principal or designee.
4. The medication is in the original container.

STATEMENT OF PHYSICIAN/NURSE PRACTITIONER

TO BE COMPLETED BY Physician/Nurse Practitioner

Name of Student: _____ Date of Birth: _____ Grade: _____
Address: _____
School: _____
Diagnosis: _____
Medication/Treatment Required: _____
Dosage: _____ Route: _____ Time/Schedule: _____
Side effects, precautions, special instructions or comments: _____
_____

I have examined the above child and determine that the above medication is medically necessary during school hours.
Physician/NursePractitioner Name *(PleasePrint)*: _____
Address: _____
Telephone: ( ) _____ Fax: ( ) _____
Physician/Nurse Practitioner Signature: _____

STATEMENT OF PARENT/GUARDIAN

TO BE COMPLETED BY Parent/Guardian

I am unable to personally administer the above medication to my child and no member of my family or relative is able to do so. I request, and hereby authorize, the school to administer the above medication as prescribed. I consent to the exchange of information between the physician/nurse practitioner with the school nurse regarding the medication and treatment.

_____ _____
Signature of Parent/Guardian *Date*

_____ _____ _____
Home Telephone # *Work Telephone #* *Cell Phone #*

_____ _____
Principal/Designee Signature *Date*