Rockbridge County Schools

Parental/Physician Consent for Administering Medication

Regulations include:

1. Written orders using this form from a physician detailing the name of the drug and the specific information below is required.
2. Using this form, signature of parent or guardian requesting that the school district comply with the physician's order is to be obtained.
3. Medication must be brought to school by parent or guardian in a container, appropriately labeled by the pharmacy or physician.
4. Schools are required to keep the medication in the original container (no pre-pouring is allowed) and under lock and key.
5. Any change of prescription requires a new written order from the prescribing physician.

Please fill in and sign this form:

Name of Student_____

Diagnosis_____ Name of Medication _____

Dates medication must be administered at school: (check one)
_____ Short Term _____ Episodic/Emergency Events Only
_____ Every Day at School _____ PRN

Dosage_____ Route_____ Time of day _____

Can serious reactions occur if the medication is not given as prescribed?
_____ Yes _____ No
If yes, describe: _____

Serious reactions/adverse side effects from this medication may occur?
_____ Yes _____ No
If yes, describe: _____

Action/Treatment for reactions: _____
Report to you? _____ Yes _____ No

Special Handling Instruction _____ Refrigeration ____ Keep out of sunlight
_____ Other _____

Physician/Licensed Prescriber Name _____ Phone Number _____
Physician/Licensed Prescriber Signature _____ Date _____

I request that the school give the above medication as ordered by the physician and I give my permission for the school to contact the physician's office regarding the medication should this be necessary.

_____ _____
Parent/Guardian Signature Phone Number