HANOVER COUNTY PUBLIC SCHOOLS
AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

The Hanover County School District requires school and Health Services to follow these guidelines:

1. **A medication request form must be signed by the parent/guardian annually, and immediately if changes occur.**
2. **Non-prescription medication must be in the original manufacturer's container and be brought to the school by parent / guardian.**
3. **Prescription medications must be brought to school by the parent in the current original properly labeled container as dispensed by the pharmacist or physician.**
4. **Medication labels must contain the student's name, name of medication, directions for use and date. Physician's order and medications label must agree.**
5. **No medication will be accepted or used if it is expired.**
6. **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 THE PARENT/GUARDIAN

Student_____ **Birthday**_____

NAME OF MEDICATION:_____ **Dosage (how much)**_____
Time to be given:_____

Reason medication given:_____
[ ] headache [ ] toothache/mouth pain [ ] muscle aches [ ] 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 non-prescription 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 school personnel who need to know.

I understand the law provides that here 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 Home_____ **Work** _____ **Cell** _____ **Email** _____

REVERSE SIDE FOR PHYSICIAN ORDERS.

TO BE COMPLETED BY PHYSICIAN

Student Name: _____ **DOB:** _____

MEDICATION TO BE ADMINISTERED AT SCHOOL _____

DOSE: _____ **ROUTE:** _____ **TIME:** _____

SPECIAL INSTRUCTIONS: _____

_____

POSSIBLE SIDE EFFECTS: _____

START DATE OF MEDICATION: _____ **DISCONTINUE DATE:** _____

SIGNATURE OF PHYSICIAN: _____ **DATE:** _____

PRINTED NAME OF PHYSCIAN AND EMERGENCY CONTACT NUMBER

_____ **PHONE #:** _____

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RETURN THIS FORM TO:

TO BE COMPLETED BY SCHOOL PERSONNEL

DATE	NUMBER RECEIVED	INITIALS

COMMENTS: _____

_____

SHORT TERM MEDICATION ADMINISTRATION ONLY

MEDICATION/DOSE	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY