## **MEDICATION PERMISSION FORM**

## PRESCRIBED MEDICATION REQUEST **Medication # Received From** Received TO BE COMPLETED BY PHYSICIAN I certify that, in my opinion, it is medically necessary that the medication described below be administered to \_\_\_\_\_ during school hours and that this medication may be administered by school personnel. Prescription: Medication \_\_\_\_\_ Dosage & Time \_\_\_\_\_ Duration Date of Prescription \_\_\_\_\_ Diagnosis requiring medication Date \_\_\_\_\_ Signature of Physician Telephone No. TO BE COMPLETED BY PARENT/LEGAL CUSTODIAN I, \_\_\_\_\_, the parent or legal custodian of request that the clinic attendant, school nurse or principal's designees administer the above medication to the above named student during the school hours and at the times indicated. I agree to furnish said medication in the **ORIGINAL** container supplied by the pharmacy with the label intact. I understand and accept that the Henrico County School Board, its employees, agents or designees are not responsible for any effects of the medication administered. Date \_\_\_\_\_ Signature of Parent/Legal Custodian Home Tel. No. \_\_\_\_\_\_ Work Tel. No. \_\_\_\_\_ NOTE: PLEASE RETURN THIS FORM WITH MEDICATION OR

MEDREQST backpage/SCHEALTH

HAVE YOUR PHYSICIAN MAIL OR FAX IT BACK TO YOUR CHILD'S SCHOOL, ATTN: CLINIC ATTENDANT/SCHOOL NURSE