STUDENT MEDICATION AUTHORIZATION FORM

WINCHESTER PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL EDUCATION
12 N. WASHINGTON STREET
WINCHESTER, VA 22601

AUTHORIZATION/PARENTAL CONSENT FOR ADMINISTERING MEDICATION

(Use a separate authorization form for each medication.)

Student's Last Name _____ Student's First Name _____ M.I. _____
Student Number _____ Grade _____ Date of Birth _____/_____/_____
Allergies: _____

Parental Consent:

I am the parent or guardian of _____. I give my permission for him/her to take the following prescribed medication while in Winchester Public Schools. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release Winchester Public Schools and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the above licensed prescriber.

_____ _____ _____
Parent/Guardian Signature Daytime phone Date

MEDICATION AUTHORIZATION
(For Use By Licensed Prescriber ONLY)

Relevant Diagnosis _____ Medication _____

Dates medication must be administered at school:
_____ Short-term (list dates to be given) _____
_____ Every day at school
_____ Episodic/Emergency Events ONLY

Dosage (Amount) _____ Route _____ Form _____ Time(s) of Day _____

A. Serious reactions can occur if the medication is not given as prescribed: _____YES _____NO
If yes, describe:

B. Serious reactions/adverse side effects from this medication may occur: _____YES _____ NO
If yes, describe:

Action/Treatment for reactions: _____

Report to you: _____YES _____ NO (Drug information sheet may be attached)

Special Handling Instructions: _____ Refrigeration _____ Keep out of sunlight _____ Other _____

Asthmatic/Diabetic <u>ONLY</u>

This student has received instruction and is both capable and responsible for self-administering this medication:

_____ NO _____ YES – Supervised _____ YES – Unsupervised

This student may carry this medication: _____ NO _____ YES

Licensed Prescriber's Name _____
Telephone Number _____ Emergency Number _____
Licensed Prescriber's Signature _____ Date _____

REGULATIONS ON THE ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

School personnel, if authorized by the responsible administrator, may assist pupils who must take prescribed medication during school hours.

A. GENERAL POLICY

1. No pupil shall be given any prescribed medications during school hours except on the written request from a licensed physician who has the responsibility for the medical management of the pupil. All such requests must be signed by the parent/guardian. Medication should be brought to the school by the parent/guardian.
2. Over-the-counter drugs will be given with medication request form completed by the parent/guardian. All medications must come to school in the original container and unopened. This apples to middle and high school students only.

B. RESPONSIBILITY OF THE PARENT/GUARDIAN

1. Parents/guardians shall be encouraged to cooperate with the physician to develop a schedule so that the necessity for taking medication at school can be minimized or eliminated.
2. Parents/guardians will assume full responsibility for the supplying of all prescribed and over-the-counter medications.
3. Parents/guardians shall deliver any medication to be administered under the provisions of this policy unless the parent/guardian decides that the child is capable of handling this responsibility.

C. RESPONSIBILITY OF THE PHYSICIAN

1. A request form for each prescribed medication must be completed by the pupil's physician, signed by the parent/guardian, and filed with the school administrator or his/her designee.
2. The container must be clearly labeled with the following information:
   a. Pupil's full name
   b. Physician's name and telephone number
   c. Name of medication
   d. Dosage, schedule and dose form
   e. Date of expiration of prescription
3. Indicate to the pharmacy if a satellite bottle needs to be prepared for the school.

D. RESPONSIBILITY OF THE SCHOOL PERSONNEL

1. The school administrator or designee will assume responsibility for placing medication in a locked cabinet.
2. Pupils will be assisted with taking medications according to the physician's instructions, and the procedure observed by a designated school staff member and recorded.
3. All discontinued and unused medications that are unclaimed will be destroyed by the school at the end of the school year.

Approved:

June 2008