

## AUTHORIZATION FOR MEDICATION ADMINISTRATION

Part I - Parent or Legal Guardian to Complete - One Medication per Form				
Student Name (Last, First, Middle)			Allergies	
Date of Birth	School Name	School/SACC Year	Grade	Teacher
Has student taken this medication before? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, the first full dose must be given at home.)				
First dose was given: Date _____ Time _____				
I/We hereby request Prince William County Public School personnel/CCC to administer medication as directed by this authorization. I/We authorize school personnel/CCC to communicate with the health care provider regarding the administration of this medication as allowed by HIPPA. I/We are aware that non-medical personnel may be administering medication to our child. I/We hereby release the Prince William County Public School Division and all of its employees/CCC of and from any and all liability in law for damages either we or our child may incur as a result of this request.				
_____ Parent or Guardian Signature		_____ Daytime Telephone		_____ Date
Part II - Physician must complete this section for all prescription medication or for any nonprescription medication that is to be given for more than the recommended duration or dosage, or when age guidelines are not followed as written on the label. Nonprescription medication to be given for relief of symptoms as directed on the package label may be given with the parent or guardian's signature, and does not require a physician's authorization and signature.				
Any necessary medication that possibly can be taken before or after school/SACC should be so prescribed. Information should be written in lay language with no abbreviations.				
Student's Diagnosis:			ICD-9 Code: (when applicable)	
Name of Medication:				
Dosage of Medication:		Route:	Time(s) or interval between times to be given:	
If medication is to be given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again.				
Effective date: <input type="checkbox"/> Current School/SACC Year _____ Or <input type="checkbox"/> From _____ To _____				Medication expires on:
_____ Physician Name (Print)		_____ Physician Signature		_____ Telephone
_____ Parent or Guardian Name (Print)		_____ Parent or Guardian Signature		_____ Date
Parent Information Regarding Medication Procedures				
The parent or guardian must transport medications to and from school/SACC. All prescription medications, including physician prescription drug samples, must be in their original containers and labeled by a physician or pharmacist. Over-the-counter medication must be in the original, sealed container. No medication will be accepted by school personnel/CCC without receipt of completed and appropriate medication forms.				
Within one week after expiration of the effective date on the physician order, or on the last day of school/SACC, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.				
A physician may use office stationery or a prescription pad in lieu of completing Part II. Faxed authorization may be acceptable as long as there is a signed parental consent. Any changes in the original medication authorization will require a new written authorization and a corresponding change in the prescription label.				