**PERMISSION FOR MEDICATION**

Roanoke City Student Health **A separate form is required for each medication**

Student Name: Date of Birth:

School: Grade: School Year:

Teacher/Team/Hall: Student ID#:

Medication: For the treatment of:

Dosage: Route:

Administration Time: : A.M. : P.M.

PRN (For OTC/PRN Prescriptions Only)

(Medication to be given within 30 minutes of time scheduled)

**Duration: Order will be valid for the above named school year including summer school unless otherwise specified.**

Possible side effects/special instructions or precautions:

I certify that, in my opinion, it is medically necessary for the medication described above to be administered during school hours and that this medication may safely be administered by appropriately trained, designated school personnel.

 Date:

*Signature of Physician, Nurse, Practitioner, Physician’s Assistant, or Dentist*

(**Prescriber’s signature is required for all prescription medications and some OTC meds)**

Printed Name of Prescriber:

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*Prescriber’s Address*

*Phone Number*

*Fax Number*

I hereby request that my child (i.e., the student named above) be given the above medication while in school and also when away from school for official activities. I understand that the medication may be given by trained non-medical school personnel, and I give permission for said trained

non-medical personnel to administer the above listed medication. I give permission for appropriate school personnel to communicate with my child’s health care provider (named above) and/or the pharmacist who filled the prescription in matters related to the medication and health supervision. I also give permission for my child’s health care provider (named above), the pharmacist who filled the prescription, and /or their designated employees to provide information about this medication and my child’s health to school personnel. I understand that medication administration will not begin until the completed health care provider and parental permission forms are on file with the school, and school personnel have received instruction concerning the administration of the medication listed above. I understand and agree that the School Board, and their officers, agents, and employees are not responsible for any effects of the medication administered.

I understand that I must promptly provide the school with written notification of any changes in my child’s condition, medication(s), or dosage. I further understand that I am responsible for ensuring the medication referenced above safely arrives at school and for getting refills of the medication as needed. I also understand that it is my responsibility to have first safely administered this medication in order to observe my child for adverse side effects and that it is my responsibility to notify the school of any such potential side effects.

I hereby give my permission for (Student Name) to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication and personally deliver it to the school. I understand that this permission form is valid for only one school year and that a new form must be completed at the beginning of each school year.

I AGREE THAT I WILL NOT SEND ANY MEDICATION WITH MY CHILD.

*Date Signature of Parent or Guardian* ***{*required for prescription and non-prescription medication}**

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*Parent/Guardian Address 1st Phone Number to Call 2nd Phone Number to Call*

**NOTE**: Prescription and non-prescription medication is to be brought to school in the original container. Prescription medication is to be appropriately labeled by the pharmacy or physician, stating name of the child, name of the prescribing physician or dentist, name of the medication, dosage and time to be given. Non-prescription medication must be in the original, unopened container labeled with the child’s name, dosage and time to be given.

**List of Staff trained to administer medication shall be maintained in School Health Clinic. Revised 02/2017**