RADFORD CITY SCHOOLS
AUTHORIZATION FOR MEDICATION ADMINISTRATION
(A separate authorization form must be used for each medication)

Student's Full Name_____ Date of Birth _____ Sex_____
School _____School Year _____ Grade _____ HR Teacher_____

ANY MEDICATION THAT IS TO BE ADMINISTERED AT SCHOOL MUST BE BROUGHT TO SCHOOL BY A PARENT OR GUARDIAN, NOT THE STUDENT. THE PRESCRIPTION MUST BE IN THE ORIGINAL BOTTLE OR BOX WITH THE CURRENT PRESCRIPTION LABEL ON THE CONTAINER. STATE LAW REQUIRES NOTIFICATION OF THE PHYSICIAN OF ANY REQUEST TO WITHHOLD, DISCONTINUE, OR CHANGE THE DOSE OR SCHEDULE OF A MEDICATION. CHANGES REQUIRE THAT A NEW AUTHORIZATION FORM BE COMPLETED.

PHYSICIAN'S CONSENT FOR MEDICATION (Licensed Prescriber Only)

Relevant Diagnosis _____Name of Medication _____
Dates medication must be administered at school (check one)
_____ Short Term (dates to be given _____)
_____ Every Day at School (duration of order _____)
_____ Episodic/Emergency Events Only** (**describe indications _____
_____)
Dosage _____Route _____ Form _____ Time(s) of Day _____
Can serious reactions occur if medication is not given as prescribed? _____ Yes _____ No _____ Unlikely
If yes, please describe _____
Serious reactions/significant side effects from medicine _____
_____
Action/Treatment for reactions _____Report any to physician? _____ Yes _____ No
Special Handling Instructions (refrigeration, out of sunlight, etc.) _____
Student able to self-administer medication? _____ Yes _____ No Student can carry inhaler? _____ Yes _____ No

_____ _____
Physician's Name (Print) Phone Number

_____ _____
Physician's Signature Date

PARENTAL CONSENT FOR MEDICATION

I am the parent/guardian of _____, I give my permission for him/her to take the above medication while at school. I understand all medications must be in the original labeled container or it cannot be given. I acknowledge that it may be necessary for the administration of medications to my child be performed by an individual other than the school nurse, and I specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school division, its employees, and agents arising out of the administration of said medication. I authorize a representative of the school to share information regarding this medication with the medical prescriber. I understand that I must notify the school of any changes in my child's condition, medication, or dosage and provide it with a new, completed authorization form to reflect these changes. This medication has been administered at least once prior to requesting administration at school.

_____ _____
Parent/Guardian Name (Print) Phone #'s (daytime and/or home and cell)

_____ _____
Parent/Guardian's Signature Date

_____ _____
Emergency Contact Name Phone #'s

NOTICE: THIS AUTHORIZATION IS ONLY VALID FOR ONE (1) SCHOOL YEAR.

February 2011