

NORTHAMPTON COUNTY PUBLIC SCHOOLS

Health Services Department

7207 Young Street

Machipongo, Virginia, 23405

npsk12.com

Phone: 757-678-5151

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Authorization/Parental Consent for Administering Medication

(Use a separate authorization form for each medication.)

STUDENT'S LAST NAME _____, 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 _____ School. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release _____ School 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 <u>ONLY</u>)	
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 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 _____





Book	Regulations
Section	J - Students
Title	Administering Medicines to Students
Code	JHCD-R
Status	Active
Adopted	August 20, 1997

If a student must take medication during school hours, it must be prescribed by a physician or dentist. Parents or guardians must supply written instructions and information concerning possible side effects, from the doctor or dentist prescribing the medication. These instructions including parental consent for administration, must be kept on file at school. In the absence of the school nurse, the principal or his/her designee may administer the medication after a review of directions by the school nurse. Medication will be stored in a locked cabinet in the school clinic. A record will be kept of all medication dispensed. Teachers should be made aware of the student's need for medication in order to excuse them at the proper time. Detailed guidelines for administration of medications may be found in Northampton County's Health Services Manual.