Attachment V
Regulation 757-3

PRINCE WILLIAM COUNTY PUBLIC SCHOOLS
AUTHORIZATION FOR MEDICATION ADMINISTRATION

Medication Expiration Date:

Student Information: Parent/Guardian to Complete

Student: _____ DOB: _____ Age: _____ Grade: _____

School: _____ Has the student taken this medication before? ☐ Yes ☐ No

If no, the first full dose must be given at home to decrease the risk of student having a negative reaction at school. First dose was given: Date: _____ Time: _____

Prescription Medication: Health Care Provider to Complete (one form for each medication)

Name of medication: _____

Diagnosis/condition for which medication is being administered:_____

Dosage: _____Route: _____Time of administration: _____

Length of time: ☐ School year ☐ Other: _____

Possible side effects: ☐ None expected ☐ Specify: _____

Health Care Provider Signature: _____ Date: _____

Health Care Provider **Printed** Name/Stamp: _____

Health Care Provider Phone Number: _____ Fax: _____

Health Care Provider Address: _____

Over-the-Counter Medication: Parent/Guardian to Complete (one form for each medication)

Name of medication: _____

Reason medication is to be given: _____

Dosage: _____ Route: _____ Time of administration: _____

Length of time: ☐ School year ☐ Other: _____

Possible side effects: ☐ None expected ☐ Specify: _____

Parent/Guardian Authorization

My signature gives permission for the principal's designee to administer prescribed/over-the-counter medication and gives the principal's designee permission to contact the health care provider if necessary. I also agree to pick up any unused medication at the end of the school year. I understand that medication not picked up by a parent/guardian at the end of the school year will be discarded. I have read the procedures and assume responsibility as required.

Parent/Guardian Signature: _____ Date: _____

To Be Completed with Health Office Staff

Medication received (amount/description): _____

Medication received: _____/_____
Health Office Staff Signature/Date Parent/Guardian Signature/Date

Medication picked up by: _____ Date: _____
Parent/Guardian Signature