Amelia County Public Schools
Authorization/ Parental Consent for Administering Medication
School Year: 20___-20___

Circle one: High School, Middle School, Elementary School

Student's Last Name_____________________, First Name_________________________, M.I._______
Grade____________Date of Birth______/______/______Teacher_________________________________
Allergies: No ____Yes____
If "yes" explain.____
____

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 understand the School Board Regulations relating to the taking of medications. I understand that unlicensed personnel may administer medications. I also give my permission for other staff members to administer medications while on field trips. I hereby release Amelia County Public School and its employees from any claims of 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 licensed prescriber.

______________________________ _______________ _______________ ____________
Parent/Guardian signature Daytime Phone Alternate phone Date

Prescription Medication Authorization

(For use by Licensed Prescriber ONLY)

Medication_____________________________ Relevant Diagnosis__________________________________
Dose_____________Route_____________ Form________________________ Time(s)__________________
When medication must be administered at school: Short term:______________________________, everyday at school _________, p.r.n.____________, Episodic/ Emergency Only_________________. A. Serious reactions can occur if the medication is not given as prescribed:____yes____no. (If yes, describe on the back of this page.)
B. Serious reactions/adverse side effects from this medication may occur:_____yes____no. (If yes, describe on the back of this page.)
Action/Treatment for reactions:____________________________Report to you_____Yes_____No (Drug information sheet may be attached.
Special Handling Instructions:_____Refridgerate,______Keep out of sunlight,_____________________other,

Asthma/Diabetic only

This student is both capable and responsible for self-administering this medication:________Yes______No
This student may carry this medication _______Yes______No

Licensed Prescriber's Name________________________________Telephone____________________

Licensed Prescriber's Signature____Date______________
(Use a separate authorization form for each medication)