Fluvanna County Public Schools
Parental Authorization/Consent for Administering Prescription Medications

(use a separate authorization form for each medication)

Student's Last Name:_____ First Name & Middle Initial:_____

Grade: _____ Date of Birth:_____

Allergies: _____

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Parental Consent

I am the parent/guardian of _____. I give my permission for him/her to take the following prescribed medication while at _____School. I hereby acknowledge that I have read and that I understand the *Fluvanna County Schools Medication Policy* related to the taking of medication. I hereby release Fluvanna County School Board and it's employees from any claim or liability connected with it's 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 medication with the prescriber named below.

_____ _____ _____

Parent/Guardian Signature Daytime Telephone Date

Prescription Medication Authorization

(For Use by Licensed Prescriber ONLY)

Relevant Diagnosis _____

Medication _____

Dates medication must be administered at school:

_____Short term (list dates to be given) _____

_____Everyday at School

_____Episodic or Emergency Events at school 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 (drug information sheet may be attached): _____

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

Special handling instructions: _____Refrigeration _____Keep out of Sunlight Other: _____

Asthmatic or Diabetic <u>ONLY</u>

This student is both capable and responsible for self-administering this medication:

_____YES – Supervised _____YES – Unsupervised _____ NO

This student may carry this medication _____YES _____ NO

Licensed Prescriber's Name (Printed) _____Phone_____

Licensed Prescriber's Signature _____ Date_____