GREENE COUNTY PUBLIC SCHOOLS

MEDICATION AUTHORIZATION FORM

(This Form must be completed yearly)

Greene County Primary 434-939-9002 Fax 985.1321
Nathanael Greene Elementary 434-939-9001 Fax 985.5287 **Ruckersville Elementary** 434-939-9006 Fax 434- 990-2657
William Monroe Middle 434-939-9003 Fax 985.1359 **William Monroe High** 434-939-9004 Fax 985-1461

We attempt to discourage administration of medication in the schools. However, if your medical provider decides it is necessary for your child to receive a medication during the school day, the following guidelines must be followed.

- It is recommended that the first doses of medication be administered at home.
- **Prescription medication must be brought to school by an adult**. The prescription pills will also need to be counted in the presence of school personnel and a form should be completed by the adult and school personnel.
- All medication needs to be in the original bottle or box with the current prescription label on the container. Upon request, most pharmacists will provide you with a duplicate bottle to keep a portion of the prescription at home.
- Both prescription and non-prescription medication must be labeled with the student's name, medication name, amount to be given, and time to be given.
- All medication must be delivered to the office or clinic at the beginning of the school day.
- Medication will only be given in the clinic or school office. Students are not permitted to take any medication in the classroom or at lunch, with the exception of inhalers for asthma and if deemed necessary by medical provider in which case the student must have an ***Individualized Health Care Plan***.
- Students who are granted permission to carry and self administer medications must sign a ***Contract for Self-Carried/Administer Medication.***

NAME OF STUDENT _____ DATE OF BIRTH _____

GRADE/TEACHER _____

MEDICATION NAME _____

REASON FOR TAKING
MEDICATION_____

AMOUNT TO BE GIVEN (How many mg?) _____

TIME(S) TO BE GIVEN _____

NUMBER OF DAYS TO BE GIVEN _____

PHYSICIAN NAME_____ PHYSICIAN PHONE/FAX NUMBER_____

I/We, the parent/guardian, authorize the school to assist our child in taking oral medication. I/We also agree that we will not hold liable any member of the school staff who is directed by us (the parents) and the school administrator to assist our child in taking the above medication.

_____ _____
Signature of parent/guardian Date

TO BE COMPLETED BY MEDICAL PROVIDER (only for Prescription Medication)

_____ _____ _____
Signature of Medical Provider Date Printed name of Medical Provider

_____ ☐ NECESSARY to carry at all times. Student has demonstrated the knowledge and ability to self administer this medication properly and safely.
Initials

_____ ☐ NOT necessary to have with them at all times.
Initials

Revised 09/17