

**CHESTERFIELD COUNTY PUBLIC SCHOOLS
CHESTERFIELD COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES**

MEDICATION ADMINISTRATION REQUEST

To Be Completed by Parent or Guardian

NAME OF STUDENT: _____

PHYSICIAN/PHYSICIAN'S ASSISTANT/NURSE PRACTITIONER: _____
(for Prescription Medication Only)

NAME OF MEDICATION: _____

DOSAGE AND TIME OF ADMINISTRATION AT SCHOOL: _____

BEGINNING DATE: _____ ENDING DATE: _____

I, _____, parent or legal guardian of _____, request that designated school personnel, under the supervision of the principal and in consultation with a school nurse or school nurse supervisor assigned by Chesterfield Health Department, administer the above medication to _____ during the times indicated. I agree to furnish said medication in the original container with the label intact. I understand and accept that the Chesterfield County School Board, its employees, agents, or designees are not responsible for any effects of the medication administered when it is administered correctly as directed above.

I also agree to pick up unused medication from the school clinic at the end of the school year no later than the last school working day in June. Failure to do so will result in the medication being disposed of by appropriate school personnel after that date.

Parent/Guardian Signature

Date

ASTHMATIC/DIABETIC/SEVERE ALLERGY ONLY

I request my child self-administer the above medication. I verify he/she is capable and responsible for self-administering the medication. Self-administration should be:

- With Assistance Without Assistance

I will provide physician's/physician's assistant's/nurse practitioner's authorization for self-administration.

Parent/Guardian Signature

Date

