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 <u>ONLY</u>

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

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FORM 1075

SCHOOL MEDICATION RECORD
SCHOOL YEAR:_____

_____

Last Name First Middle Grade Date of Birth

Diagnosis:_____Mediction:_____Dosage:_____ _____Time of Administration:_____

Physician/Physician's Assistant/Nurse Practitioner:_____ Instructions:_____

Home Phone:_____ Business Phone (Father):_____ Business Phone (Mother):_____

BELOW SECTION FOR SCHOOL USE ONLY

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Sept. Time Adm./ Initials																															
Oct. Time Adm./ Initials																															
Nov. Time Adm./ Initials																															
Dec. Time Adm./ Initials																															
Jan. Time Adm./ Initials																															
Feb. Time Adm./ Initials																															
Mar. Time Adm./ Initials																															
April Time Adm./ Initials																															
May Time Adm./ Initials																															
June Time Adm./ Initials																															

Signature and Initials:_____ Signature and Initials:_____Signature and Initials:_____

INSTRUCTIONS:

1. **Record time(s) and initial in box when medication is given.**
2. **Record "SA" if student self administers medication.**
3. **Record "AB" if student is absent, "FT" Field Trip, "NM" No Medication.**
4. **Sign and initial bottom of form for identification.**
5. **Record unusual circumstances in comment section.**
6. **Include form in health record if pupil transfers to another school.**

COMMENTS:

_____

_____

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