

MEDICATION PERMISSION FORM

| <u>Received</u> | <u>Medication #</u> | <u>Received From</u> |
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PRESCRIBED MEDICATION REQUEST

TO BE COMPLETED BY PHYSICIAN

I certify that, in my opinion, it is medically necessary that the medication described below be administered to _____ during school hours and that this medication may be administered by school personnel.

Prescription:

Medication _____
Dosage & Time _____
Duration _____
Date of Prescription _____
Diagnosis requiring medication _____

Date _____
Signature of Physician _____
Telephone No. _____

TO BE COMPLETED BY PARENT/LEGAL CUSTODIAN

I, _____, the parent or legal custodian of _____ request that the clinic attendant, school nurse or principal's designees administer the above medication to the above named student during the school hours and at the times indicated. I agree to furnish said medication in the **ORIGINAL** container supplied by the pharmacy with the label intact. I understand and accept that the Henrico County School Board, its employees, agents or designees are not responsible for any effects of the medication administered.

Date _____
Signature of Parent/Legal Custodian _____
Home Tel. No. _____
Work Tel. No. _____

NOTE: PLEASE RETURN THIS FORM WITH MEDICATION OR HAVE YOUR PHYSICIAN MAIL OR FAX IT BACK TO YOUR CHILD'S SCHOOL, ATTN: CLINIC ATTENDANT/SCHOOL NURSE