Administration of Medication

Administration of medications, especially short term, should be done at home whenever possible. However, if a student is required to take prescription or non-prescription medication during the school day, the following guidelines must be met:

- A written order from the physician, dentist, or practitioner is required, stating the student's name ,the name of medication , the dosage, the time, the route (oral, injectable, inhaled, patch, etc.),and the duration of time that it is to be given (e.g., one week, the school year, etc.), along with the parent's/guardian's signature. Medication forms are available for your convenience in the school clinic.
- Medication must be in a container that has been labeled by the pharmacy and has the most current prescription date. Over-the-counter medication must be in a sealed, unopened new bottle.
- Parent /guardian must deliver medication to the school clinic, as students are not permitted to transport medication.
- All medicine must be picked up by a parent at the end of the school year. Medicine that is not picked up will be disposed.

In some situations, accommodations can be made for students with asthma and with potential for severe allergic reactions to self-administer their inhaled asthma medication or their auto-injectable (Epi-pen) medication. These situations require written health care plans, along with other specific details for care. Additional questions and concerns may be directed to the nurse at your school.

Please sign below:

I acknowledge I have read the above information.

_____ _____ _____

Parent/Guardian Print Parent /Guardian Signature Date

DEPARTMENT OF SPECIAL EDUCATION & STUDENT SERVICES
CHARLOTTESVILLE CITY SCHOOLS
CHARLOTTESVILLE, VIRGINIA 22901

Name of Student: _____ DOB:_____

School: _____ Grade: _____

Medication and dosage: _____

_____

Purpose of the medication:_____

Time of day medication is given: _____

Possible side effects: _____

Anticipated Number of days medication needs to be given: _____

Name of Physician: _____ Phone: _____

Physician Signature: _____Date: _____

☐ **PHYSICIAN: Please check if this is an inhaler and the student has physician permission to carry the inhaler at all times during the school day.**

My signature below serves as permission for the school nurse to contact the physician named above to discuss the medication or obtain a signature that may be faxed to the child's school.

I hereby give permission for _____to take the above named
(Student Name)
medication at school as prescribed. I understand it is my responsibility to furnish this medication. *Prescription medication* is to be brought in the original bottle from the pharmacy, stating the name of the student, the name and dosage of the medication, and the name of the physician. *Over the counter medication* is to be brought in the original sealed, unopened container.

_____ _____ _____
Print Parent/Guardian Name Signature Date

Home Phone: _____Work Phone: _____

Cell Phone: _____

Email: _____

School Fax:_____