

# 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 trip.

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

**PARENT:** Please check *if this is an inhaler* and you give permission for your child to take the inhaler home at the end of the school year.

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

School Fax: \_\_\_\_\_

**PLEASE READ AND COMPLETE THE BACK OF THIS FORM.**