Amherst County Public Schools
Authorization/Parental Consent for Administering Prescription Medication/Non-Prescription Medication
(Use separate authorization form for each medication)
(New authorization required at the beginning of each school year)

Child's Name ________________________________Date of Birth___________________Grade__________
Medication Name____
Exact Dose to be given____
Exact beginning and ending dates to be given (including day, month, year)______________________________
Exact time to be given____
Reason for medication____
Medication allergies____
Special Instructions____

I, _____________________________, the parent or guardian of ________________________ hereby request that the school nurse or member of the staff at ____________________School administer certain medications and treatment to my son/daughter. I understand that the person at the school who will administer this medication or treatment may be inexperienced and untrained in this requested service and state, without reservation, that I shall not hold him/her or the Amherst County School Board liable in any way for any harm or injury that may be experienced by my child as a result of this service. I authorize a representative of the school to share information regarding prescribed medication with the licensed prescriber.

______________________________________ ___________ ______________________________
Signature of Parent/Guardian Date Emergency Contact Name

Home phone: ___________________________ Emergency phone: ___________________
Work Phone: (Mother) __________________
(Father) ___________________

Prescription Medication/Non-Prescription Medication Authorization
(For Use by Licensed Prescriber ONLY)

Relevant Diagnosis ____

Medication ______________________________ Dose _____________ Time of day ___________Route_______
Dates medication must be administered at school:
_____Short Term (List dates to be given ____)
_____Every day at school
_____Episodic/Emergency Events ONLY
Please describe any serious reactions/adverse affects that may occur with this medication
____

For Inhalers, EpiPens and Diabetic medications ONLY
____ Student knows how to properly use medication and may carry med with them at all times
____ Student should be supervised by staff when taking medication

Special Instructions ____

Licensed Prescriber's Name (please print) ______________________________Telephone # ________________

Licensed Prescriber's Signature ________________________________ Date ____________________