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 _____