LOUDOUN COUNTY PUBLIC SCHOOLS
AUTHORIZATION FOR MEDICATION ADMINISTRATION BUS#____

PARENT/ GUARDIAN SECTION

Student______________________________ DOB____________ Age_______ Grade__________

School______________________________ Homeroom Teacher____________________________

Parent/ Guardian Signature______________________________ Date____________________

Parent/ Guardian Printed Name____

Signature gives permission for principal's designee to administer prescribed medicine and gives principal's designee permission to contact physician/ dentist if necessary. For Over-the-Counter medicine, parent's signature gives principal's designee permission to administer medicine.

PHYSICIAN/ DENTIST SECTION

(Must be completed by Physician/ Dentist)

PRESCRIPTION MEDICATIONS:

Name of Medication:____

Reason medication is needed, unless confidential:__________________________________

Dosage:______________________________ Length of Time:______________________________

Time of day to be given:____

If potentially serious side effects exist, please outline any necessary emergency response on a separate sheet.

Physician/ Dentist Signature______________________________________ Date:______________

Physician/ Dentist PRINTED Name____

Physician/ Dentist Phone__________________________________ Fax__________________________

Physician/ Dentist Address____

OVER-THE-COUNTER MEDICATIONS:

Name of Medication:____

Dosage/ Length of Time:____

Time of Day to be Given:____

Side Effects:____

Received By:____ **Date:**______________________

DISTRIBUTION: Original to be kept with medication, Copy to Student Health Record, Copy to Physician