PRESCRIBED MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PHYSICIAN

I certify that, in my opinion, it is medically necessary that the medication described below be administered to_____ during school hours and that this medication be administered by school personnel.

Student: _____ **DOB:** _____
Reason for medication: _____
Name of medication: _____
Dosage and Time: _____
Symptoms for repeating medication: _____
Duration: _____
Date of prescription: _____
Date: _____ **Name of physician:** _____
(Print)

Signature of physician: _____

Note: Please return this form with medication or have your physician mail or fax it back to your child's school, Attention: School Nurse.

Attachment A
Section 2

OVER-THE-COUNTER MEDICATION REQUEST

Student: _____
DOB: _____
Reason(s) medication is to be given: _____
Name of Medication: _____
Dosage and time to be given at school: _____
Duration: _____

I, _____, the parent/legal custodian of _____, request that the clinic attendant/school nurse, or principal's designees administer the above medication to _____ during school hours and at the times indicated. I agree to furnish said medication in the **ORIGINAL** container supplied by the pharmacy with the label intact. I understand and accept that the Prince William County School Board, its employees, agents, or designees are not responsible for any effects of the medication administered. **A physician must authorize in writing any nonprescription medication that is to be given for more than three (3) consecutive school days.**

Date: _____ _____
Signature of Parent/Legal Custodian

RELEASE AND INDEMNIFICATION AGREEMENT BY PARENTS REQUESTING PRINCE WILLIAM COUNTY PUBLIC SCHOOLS TO DISPENSE MEDICINE TO STUDENTS

(Complete a separate form for each student to receive medication.)

FOR AND IN CONSIDERATION of the service of Prince William County Public Schools (PWCPS) administering medicine to my/our child at my/our request, I/we, the undersigned parents and/or guardian of _____, do forever release and covenant to hold harmless the PWCPS, Prince William County School Board (PWCSB), and their employees, representatives, and agents from any and all claims or causes of action for injuries, costs, or other damages which I/we or our/my child may hereafter have as a result of the dispensing of medicine by the PWCPS pursuant to this agreement whether or not caused or contributed to by any negligence or alleged negligence on the part of the PWCPS, its agents or employees.

I/WE FURTHER PROMISE to bind myself/ourselves, my/our heirs, administrators, and executors to repay to the PWCPS, PWCSB, and their employees, agents, and representatives any sum of money that it/they may hereafter be compelled to pay in any way connected with the dispensing of medicine by the PWCPS pursuant to this agreement.

IT IS FURTHER AGREED AND UNDERSTOOD that I/we request PWCPS to administer medicine to my/our child in the manner noted on the physician's authorization. The subject medicine is medically necessary, and I/we request this service as I/we find that I/we cannot personally administer the medicine during school hours.

IT IS FURTHER AGREED AND UNDERSTOOD that the PWCPS is not able to provide medical staff to administer medicine, and therefore, the person dispensing the medicine may be a school staff member trained to administer medication in accordance with Code of Virginia §54.1-3408. It is my/our responsibility to decide whether to entrust administration of medication to a staff member so designated.

IT IS FURTHER AGREED AND UNDERSTOOD that it is my/our responsibility to ensure that the medicine is properly labeled as to its nature and the means of its administration. It is also my/our responsibility to ensure that the medicine is fresh and adequately stored, and that an adequate supply is kept at the school. If the dosage changes or the medication is to be stopped prior to the time noted in the prescription, it is my/our responsibility to communicate the change clearly, in writing, to school staff. PWCPS will not increase a dosage without a new written authorization from the physician.

I/WE CONSENT to the above conditions and acknowledge that the PWCPS is acting as my/our agent in administering medication to my/our child.

I/WE FURTHER STATE that the foregoing release and indemnification agreement has been carefully read and I/we know of the contents thereof and have signed the same by my/our own free act.

CAUTION: READ BEFORE SIGNING BELOW

Medication requested to be administered:_____

_____ _____

Name of Parent/Guardian (Printed) Signature of Parent/Guardian

_____ _____

Child's Name (Printed) Date

(This agreement must be signed and returned to the building principal before medication can be administered.)